DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410 and 414

[HCFA-1120-P]

RIN 0938-AK11

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2001

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would make several changes affecting Medicare Part B payment. The changes include: refinement of resource-based practice expense relative value units (RVUs); changes to the geographic practice cost indices; resource-based malpractice RVUs; critical care RVUs; care plan oversight and physician certification/recertification; observation care codes; ocular photodynamic therapy and other ophthalmological treatments; electrical bioimpedance; the global period for insertion, removal, and replacement of pacemakers and cardioverter defibrillators; antigen supply; low intensity ultrasound; and the implantation of ventricular assist devices. This proposed rule also discusses or clarifies the payment policy for incomplete medical direction, pulse oximetry services, outpatient therapy supervision, outpatient therapy caps, and the second 5-year refinement of work RVUs for services furnished

beginning January 1, 2002. We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We solicit comments on the proposed policy changes.

DATES: To be assured of consideration, we must receive comments at the appropriate address, as provided below, no later than 5 p.m. on **[60 days after the date of publication in the Federal Register]**.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address only:

Health Care Financing Administration,

Department of Health and Human Services,

Attention: HCFA-1120-P,

P.O. Box 8013,

Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays. If you prefer, you may deliver your written comments by courier (1 original and 3 copies) to one of the following addresses:

Room 443-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201 or

Room C5-14-03,

7500 Security Boulevard,

Baltimore, MD 21244.

Comments mailed to the two above addresses may be delayed and received too late to be considered.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1120-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443-G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 to 5 p.m. (phone: (202) 690-7890).

FOR FURTHER INFORMATION CONTACT:

Bob Ulikowski, (410) 786-5721 (for issues related to resource-based malpractice relative value units and geographic practice cost index changes).

Carolyn Mullen, (410) 786-4589 or Marc Hartstein, (410) 786-4539, (for issues related to resource-based practice expense relative value units).

Rick Ensor, (410) 786-5617 (for issues related to care plan oversight and physician certification/recertification).

Jim Menas, (410) 786-4507 (for issues related to incomplete medical direction and the 5-year review).

Roberta Epps, (410) 786-1858 (for outpatient therapy-related issues).

Cathleen Scally, (410) 786-5714 (for issues related to observation care codes).

Diane Milstead, (410) 786-3355 (for all other issues).

SUPPLEMENTARY INFORMATION:

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Information on the Lewin report referenced in the preamble can be found on our homepage. This data can be accessed by using the following directions:

1. Go to the HCFA homepage (http://www.hcfa.gov).
2. Click on "Medicare."
3. Click on "Professional/Technical Information."
4. Select Medicare Payment Systems.
5. Select Physician Fee Schedule.

Or, you can go directly to the Physician Fee Schedule page by typing the following: http://www.hcfa.gov/medicare/pfsmain.htm.

To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations.

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In addition, because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AMA	American Medical Association
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act
CF	Conversion factor
CFR	Code of Federal Regulations
CPT	[Physicians'] Current Procedural Terminology [4th Edition, 1997, copyrighted by the American Medical Association]
CPEP	Clinical Practice Expert Panel

CRNA	Certified Registered Nurse Anesthetist
E/M	Evaluation and management
EB	Electrical bioimpedance
FMR	Fair market rental
GAF	Geographic adjustment factor
GPCI	Geographic practice cost index
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HHA	Home health agency
HHS	[Department of] Health and Human Services
IDTFs	Independent Diagnostic Testing Facilities
MCM	Medicare Carrier Manual
MEDPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MGMA	Medical Group Management Association
MSA	Metropolitan Statistical Area
NAMCS	National Ambulatory Medical Care Survey
OBRA	Omnibus Budget Reconciliation Act
PC	Professional component
PEAC	Practice Expense Advisory Committee
PPAC	Practicing Physicians Advisory Council
PPS	Prospective payment system
RUC	[AMA's Specialty Society] Relative [Value] Update Committee

RVU Relative value unit

SGR Standard growth rate

SMS [AMA's] Socioeconomic Monitoring System

TC Technical component

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physician services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." This section contains three major elements--(1) a fee schedule for the payment of physicians' services; (2) a sustainable growth rate for the rates of increase in Medicare expenditures for physicians' services; and (3) limits on the amounts that nonparticipating physicians can charge beneficiaries. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense.

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than $20 million, we

must make adjustments to the conversion factors (CFs) to preserve budget neutrality.

B. Published Changes to the Fee Schedule

We published a final rule on November 25, 1991 (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physicians' services furnished on or after January 1, 1992. In the November 1991 final rule (56 FR 59511), we stated our intention to update RVUs for new and revised codes in the American Medical Association's (AMA's) Physicians' Current Procedural Terminology (CPT) through an "interim RVU" process every year. We published the updates to the RVUs and fee schedule policies are as follows:

- November 25, 1992, a final notice with comment period on new and revised RVUs only (57 FR 55914).

- December 2, 1993, a final rule with comment period (58 FR 63626) revised the refinement process used to establish physician work RVUs and to revise payment policies for specific physicians' services and supplies. (We solicited comments on new and revised RVUs only.)

- December 8, 1994, a final rule with comment period (59 FR 63410) revised the geographic adjustment factor (GAF) values, fee schedule payment areas, and payment policies for specific physicians' services. The final rule also discussed the process for periodic review and adjustment of RVUs not less

frequently than every 5 years as required by section 1848(c)(2)(B)(i) of the Act.

• December 8, 1995, a final rule with comment period (60 FR 63124) revised various policies affecting payment for physicians' services including Medicare payment for physicians' services in teaching settings, the RVUs for certain existing procedure codes, and established interim RVUs for new and revised procedure codes. The rule also included the final revised 1996 geographic practice cost indices (GPCIs).

• November 22, 1996, a final rule with comment period (61 FR 59490) revised the policy for payment for diagnostic services, transportation in connection with furnishing diagnostic tests, changes in geographic payment areas (localities), and changes in the procedure status codes for a variety of services.

• October 31, 1997, a final rule with comment period (62 FR 59048) revised the GPCIs, physician supervision of diagnostic tests, establishment of independent diagnostic testing facilities, the methodology used to develop reasonable compensation equivalent limits, payment to participating and nonparticipating suppliers, global surgical services, caloric vestibular testing, and clinical consultations. It also implemented certain provisions of the Balanced Budget Act of 1997 (BBA) (Public Law 105-33), enacted on August 5, 1997, and

implemented the RVUs for certain existing procedure codes and established interim RVUs for new and revised procedure codes.

- November 2, 1998, a final rule with comment period (63 FR 58814) revised the policy for resource-based practice expense RVUs, medical direction rules for anesthesia services, and payment for abnormal Pap smears. We also rebased the Medicare economic index (MEI) from a 1989 base year to a 1996 base year. Under the law, we were also required to develop a resource-based system for determining practice expense RVUs. The BBA delayed, for 1 year, implementation of the resource-based practice expense RVUs until January 1, 1999. Also, the BBA revised our payment policy for nonphysician practitioners, for outpatient rehabilitation services, and for drugs and biologicals not paid on a cost or prospective payment basis. In addition, the BBA permitted certain physicians and practitioners to opt out of Medicare and furnish covered services to Medicare beneficiaries through private contracts and permits payment for professional consultations via interactive telecommunication systems. Furthermore, we finalized the 1998 interim RVUs and issued interim RVUs for new and revised codes for 1999. The final rule also announced the CY 1999 Medicare physician fee schedule CF under the Medicare Supplementary Medical Insurance (Part B) program as required by section 1848(d) of the Act. The 1999 Medicare physician fee schedule CF was $34.7315.

• November 2, 1999, a final rule with comment period (64 FR 59380) made several changes affecting Medicare Part B payment. The changes included: implementation of resource-based malpractice insurance RVUs; refinement of resource-based practice expense RVUs; payment for physician pathology and independent laboratory services; discontinuous anesthesia time; diagnostic tests; prostate screening; use of CPT modifier -25; qualifications for nurse practitioners; an increase in the work RVUs for pediatric services; adjustments to the practice expense RVUs for physician interpretation of Pap smears; and a number of other changes relating to coding and payment. Furthermore, we finalized the 1999 interim physician work RVUs and issued interim RVUs for new and revised codes for 2000. The final rule solicited public comments on the second 5-year refinement of work RVUs for services furnished beginning January 1, 2002 and requested public comments on potentially misvalued work RVUs for all services in the CY 2000 physician fee schedule. The final rule conformed the regulations to existing law and policy regarding: removal of the x-ray as a prerequisite for chiropractic manipulation; the exclusion of payment for assisted suicide; and optometrist services. The final rule also announced the CY 2000 Medicare physician fee schedule CF under the Medicare Supplementary Medical Insurance (Part B) program as required by

section 1848(d) of the Act. The 2000 Medicare physician fee schedule CF was $36.6137.

This proposed rule would affect the regulations set forth at Part 410, Supplementary medical insurance (SMI) benefits and Part 414, Payment for Part B medical and other services.

II. Specific Proposals for Calendar Year 2001

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Public Law 103-432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we must apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the BBA delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to

resource-based RVUs. The practice expense RVUs for CY 1999 were the product of 75 percent of charge-based RVUs and 25 percent of the resource-based RVUs. For CY 2000, the RVUs were 50 percent charge-based and 50 percent resource-based. For CY 2001, the RVUs will be 25 percent charge-based and 75 percent resource-based. After CY 2001, the RVUs will be totally resource-based.

Section 4505(e) of the BBA provided that, in 1998, the practice expense RVUs be adjusted for certain services in anticipation of implementation of resource-based practice expenses beginning in 1999. As a result, we increased practice expense RVUs for office visits. For other services in which practice expense RVUs exceeded 110 percent of the work RVUs and were furnished less than 75 percent of the time in an office setting, we reduced the 1998 practice expense RVUs to a number equal to 110 percent of the work RVUs. This limitation did not apply to services that had proposed resource-based practice expense RVUs that increased from their 1997 practice expense RVUs as reflected in the June 18, 1997 proposed rule (62 FR 33196). The services affected, and the final RVUs for 1998, were published in the October 1997 final rule (62 FR 59103).

The most recent legislation affecting resource-based practice expense was included in the Balanced Budget Refinement Act of 1999 (BBRA) (Public Law 106-113). Section 212 of the BBRA stated that we must establish a process under which we accept and

use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002.

2. Current Methodology for Computing Practice Expense Relative Value Unit System

Effective with services on or after January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available: the Clinical Practice Expert Panel (CPEP) data and the AMA's Socioeconomic Monitoring System (SMS) data. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach. The methodology can be summarized as follows:

(a) Practice Expense Cost Pools.

We used actual practice expense data by specialty, derived from the 1995 through 1997 SMS survey data, to create six cost pools -- administrative labor, clinical labor, medical supplies,

medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools.

• Step 1) We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category. The practice expenses per hour for each physician respondent's practice was calculated as the practice expenses for the practice divided by the total number of hours spent in patient care activities. The practice expenses per hour for the specialty were an average of the practice expenses per hour for the respondent physicians in that specialty. In addition, for the CY 2000 physician fee schedule, we used data from a survey submitted by the Society of Thoracic Surgeons in calculating the thoracic and cardiac surgery's practice expense per hour. (See the November 1999 final rule (64 FR 59391) for additional information concerning acceptance of this data.)

• Step 2) We determined the total number of physician hours (by specialty) spent treating Medicare patients. This was calculated from physician time data for each procedure code and from Medicare claims data.

• Step 3) We calculated the practice expense pools by specialty and by cost category by multiplying the specialty practice expenses per hour for each category by the total physician hours.

For services with work RVUs equal to zero (including the technical component (TC) of services with a TC and professional component (PC)), we created a separate practice expense pool using the average clinical staff time from the CPEP data (since these codes by definition do not have physician time), and the "all physicians" practice expense per hour.

(b) Cost Allocation Methodology.

For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group.

(1) Direct Costs

For direct costs (including clinical labor, medical supplies, and medical equipment), we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively.

For the separate practice expense pool for services with work RVUs equal to zero, we used 1998 practice expense RVUs to allocate the direct cost pools (clinical labor, medical supplies, and medical equipment cost pools) as an interim measure. Also, for all radiology services that are assigned work RVUs, we used the 1998 practice expense relative values for radiology services as an interim measure to allocate the direct practice expense

cost pool for radiology. For all other specialties that perform radiology services, we used the CPEP data for radiology services in the allocation of that specialty's direct practice expense cost pools.

(2) Indirect Costs

To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs, as described above, in combination with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

The SMS pool was divided by the CPEP pool for each specialty to produce a scaling factor that was applied to the CPEP direct cost inputs. This was intended to match costs counted as practice expenses in the SMS survey with items counted as practice expense in the CPEP process. When the specialty specific scaling factor exceeds the average scaling factor by more than three standard deviations, we used the average scaling factor. (See the November 1999 final rule (64 FR 59390) for further discussion of this issue).

For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with

the weights being the frequency with which each specialty performs the procedure on Medicare patients.

(c) Other Methodological Issues.

(1) Global Practice Expense Relative Value Units

For services with the PC and TC paid under the physician fee schedule, the global practice expense RVUs were set equal to the sum of the PC and TC.

(2) Practice Expenses per Hour Adjustments and Specialty Crosswalks

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the practice expense tables from the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty category. We also made the following adjustments to the practice expense per hour data (for the rationale for these adjustments to the practice expense per hour see the November 1998 final rule (63 FR 58841):

- We set the medical materials and supplies practice expenses per hour for the specialty of "oncology" equal to the "all physician" medical materials and supplies practice expenses per hour.

- We based the administrative payroll, office, and other practice expenses per hour for the specialties of "physical therapy" and "occupational therapy" on data used to develop the

salary equivalency guidelines for these specialties. We set the remaining practice expense per hour categories equal to the "all physician" practice expenses per hour from the SMS survey data.

- Due to uncertainty concerning the appropriate crosswalk and time data for the nonphysician specialty "audiologist," we derived the resource-based practice expense RVUs for codes performed by audiologists from the practice expenses per hour of the other specialties that perform these codes.

- For the specialty of "emergency medicine," we used the "all physician" practice expense per hour to create practice expense cost pools for the categories "clerical payroll" and "other expenses."

- For the specialty of "podiatry," we used the "all physician" practice expense per hour to create the practice expense pool.

- For the specialty of "pathology," we removed the supervision and autopsy hours reimbursed through Part A of the Medicare program from the practice expense per hour calculation.

- For the specialty "maxillofacial prosthetics," we used the "all physician" practice expense per hour to create practice expense cost pools and, as an interim measure, allocated these pools using the 1998 practice expense RVUs.

- We split the practice expenses per hour for the specialty "radiology" into "radiation oncology" and "radiology other than

radiation oncology" and used this split practice expense per hour to create practice expense cost pools for these specialties.

(3) Time Associated with the Work RVUs

The time data resulting from the refinement of the work RVUs have been, on average, 25 percent greater than the time data obtained by the Harvard study for the same services. We increased the Harvard research team's time data to ensure consistency between these data sources.

For services with no assigned physician time (such as, dialysis, physical therapy, psychology, and many radiology and other diagnostic services), we calculated estimated total physician time based on work RVUs, maximum clinical staff time for each service as shown in the CPEP data, or the judgment of our clinical staff.

We calculated the time for CPT codes 00100 through 01996 using the base and time units from the anesthesia fee schedule and the Medicare allowed claims data.

3. Refinement

(a) Background

Section 4505(d)(1)(C) of the BBA required us to develop a refinement process to be used during each of the 4 years of the transition period. We did not propose a specific long-term refinement process in the June 1998 proposed rule (63 FR 30835). Rather, we set out the parameters for an acceptable refinement

process for practice expense RVUs and solicited comments on our proposal. We received a large variety of comments about broad methodology issues, practice expense per hour data, and detailed code level data. We made some adjustments to our proposal when we were convinced an adjustment was appropriate. We also indicated that we would consider other comments for possible refinement and that the values of all codes would be considered interim for 1999 and for future years during the transition period.

We outlined in the November 1998 final rule (63 FR 58832) the steps we were undertaking as part of the initial refinement process. These steps included--

- Establishment of a mechanism to receive independent advice for dealing with broad practice expense RVU technical and methodological issues;
- Evaluation of any additional recommendations from the General Accounting Office, the Medicare Payment Advisory Commission (MedPAC), and the Practicing Physicians Advisory Council (PPAC); and
- Consultation with physician and other groups about these issues.

We also discussed a proposal submitted by the AMA's Specialty Society Relative Value Update Committee (RUC) for development of a new advisory committee, the Practice Expense

Advisory Committee (PEAC), to review comments and recommendations on the code-specific CPEP data during the refinement period. In addition, we solicited comments and suggestions about our practice expense methodology from organizations that have a broad range of interests and expertise in practice expense and survey issues.

In the July 22, 1999 proposed rule and the November 1999 final rule, we provided further information on refinement activities underway, including the formation of the PEAC and the support contract that we awarded to focus on methodologic issues. The following is an update on activities with respect to these initiatives, as well as the status of refinement with respect to other areas of concern such as the SMS data and CPEP inputs.

(b) SMS Data

We have received many comments on both our 1998 and 1999 proposed and final rules from a number of medical specialty societies expressing concerns regarding the accuracy of the SMS data. Some commenters stated their belief that the sample size for their specialty was not large enough to yield reliable data. Other specialties not represented in the SMS survey objected that the crosswalk used for their practice expense per hour was not appropriate and requested that their own data be used instead. Commenters also raised questions about whether the

direct patient care hours for their specialty were overstated by the SMS to the specialty's disadvantage.

We consider dealing with these issues to be one of the major priorities of the refinement effort. Therefore, we have undertaken the following activities:

(1) Interim Final Rule on Supplemental Practice Expense Survey Data

On May 3, 2000, we published an interim final rule (65 FR 25664) that set forth the criteria for physician and non-physician specialty groups to submit supplemental practice expense survey data for use in determining payments under the physician fee schedule. Section 212 of the BBRA required us to establish a process under which we will accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002.

To obtain data that could be used in computing practice expense RVUs beginning January 1, 2001, we published the criteria in the May 2000 interim final rule (65 FR 25666) that we will apply to supplemental survey data submitted to us by August 1, 2000. We also provided a 60-day period for submission of comments on the criteria that we will consider for survey data

submitted between August 2, 2000 and August 1, 2001 for use in computing the practice expense RVUs for the CY 2002 physician fee schedule. (See the May 2000 interim final rule for further information on the criteria and process). We intend to respond to comments received on this interim final rule in the physician fee schedule final rule to be published this fall. We believe this is an important step in addressing the concerns of those specialties that believe they are underrepresented in the SMS survey data or believe they have not been surveyed by the SMS.

(2) Proposals for SMS Refinement

As we indicated in the November 1999 final rule, we awarded a contract to The Lewin Group to obtain independent advice dealing with broad practice expense RVU technical and methodological issues. Specific activities we requested the contractor to evaluate included the following:

- Evaluation of SMS data for validity and reliability.
- Identification and evaluation of alternative and supplementary data sources from specialty and multi-specialty societies.
- Development of options for validating the Harvard/RUC physician procedure time data.
- Evaluation of the indirect cost allocation methodology.
- Advice on developing a process for the 5-year review of practice expense RVUs.

The Lewin Group issued their first draft report, "Practice Expense Methodology," dated September 24, 1999. We have placed this report on our homepage under the title "Practice Expense Methodology Report." (Access to our homepage is discussed under the "Supplementary Information" section above.) The report contains various recommendations aimed at increasing the validity and reliability of the AMA's SMS survey. As we discuss below, the AMA will no longer be collecting data through the SMS survey. However, the AMA is currently pilot-testing an alternative practice expense survey of physician practices. Although The Lewin Group's recommendations were made specifically to address improving the SMS survey for calculating practice expense RVUs, we believe the recommendations will be useful in making refinements to the practice level survey or designing any other survey instrument that may be used in calculating practice expense RVUs. The recommendations fell into the three following areas:

- The use of data supplementary to the SMS survey.
- Suggested changes to the survey instrument.
- Recommendations for using the data in calculating the specialty-specific practice expense per hour.

The report recognized the need for additional data obtained either through oversampling or additional surveys. We would welcome the receipt of additional objective and valid data that

would help ensure that our specialty-specific practice expense per hour calculations are as accurate as possible. However, to ensure consistency of the data across specialties, the report also stressed the need for any supplementary data to adhere to the same format, survey instrument, sample frame, and definitions as the SMS survey. We share this concern, and in the May 2000 interim final rule we identified the specific criteria that all supplementary surveys must meet to ensure that data are valid, reliable, and consistent with the SMS data already in use.

In line with the report's recommendations on the use of the SMS data, we are proposing to do the following:

• The Lewin Group recommended that we update the SMS survey data currently being used for practice expense per hour with new SMS data. They also recommended using a rolling 3-year average to determine practice expense per hour values. We are currently using data from the 1995 through 1997 SMS survey (1994 through 1996 practice expense data). The latest data available is from the 1998 SMS survey and we have incorporated this data into our practice expense per hour calculations. Although The Lewin Group has recommended using a rolling 3-year average, we have decided to base the practice expense per hour calculations on a 4-year average. We are concerned that substituting data from the 1998 SMS for data from the 1999 SMS may exacerbate changes in the practice expense per hour calculations that may be explained by

sampling error. We believe that using an additional year of SMS data will have the advantage of minimizing changes in the practice expense per hour data that result from sampling error, while allowing our calculations to be based on more survey data.

• The Lewin Group recommended that we standardize survey data from the SMS so that it reflects a common base year. They raised a concern that variations in sample size for a given specialty across the 3 years may produce a different result than if the survey response were standardized to reflect a common year. This could disadvantage those specialties that were more heavily sampled in the early years. We evaluated this recommendation and found that standardizing the SMS data we are currently using to reflect a 1995 cost year has virtually no impact on the practice expense per hour calculations. However, this issue will be more of a concern in using the later SMS data because response rates were lower in the 1998 SMS survey than in prior years. For this reason, we are standardizing the practice expense data so that it reflects a common base year. Using the MEI, we standardized the practice expense data so that it reflects a 1995 cost year consistent with the pricing information that we are using for the estimates of practice expense inputs for individual procedures.

The table below reflects the practice expense per hour calculations we are using in determining the CY 2001 practice expense RVUs.

SPECIALTY	NON-PHYS PAYROLL PER HOUR	CLERICAL* PAYROLL PER HOUR	OFFICE EXPENSE PER HOUR	SUPPLIES EXPENSE PER HOUR	EQUIPMENT EXPENSE PER HOUR	OTHER EXPENSE PER HOUR	TOTAL** EXPENSE PER HOUR
ALL PHYSICIANS	27.4	15.1	19.5	7.3	3.1	11.5	68.6
GENERAL/FAMILY PRACTICE	29.7	15	17.9	7.9	3.3	8.5	67.2
GENERAL INTERNAL MEDICINE	23.7	14.2	18	6.2	2.1	6.6	56.6
CARDIOVASCULAR DISEASE	29.9	15.1	20.9	6.4	6.2	19.8	83.2
GASTROENTEROLOGY	24.8	16.4	18.7	3	1.9	11.7	60.1
ALLERGY/IMMUNOLOGY	64.3	27.1	31.4	17.1	3.1	16.6	132.5
PULMONARY DISEASE	18	11.5	14.9	2.4	1.5	6.5	43.4
ONCOLOGY	50.2	23.1	27.4	7.3	4.8	9.1	98.8
GENERAL SURGERY	22.2	15.3	17	3	1.8	10	54.1
OTOLARYNGOLOGY	43.1	24.6	32.8	7.5	5.7	18.1	107.2
ORTHOPEDIC SURGERY	45.2	27.9	29.9	10.4	3.7	19	108.3
OPHTHALMOLOGY	52.6	26.7	35.3	10.5	8.3	21.4	128.1
UROLOGICAL SURGERY	30	17.6	23.8	24.9	5.7	11.1	95.6
PLASTIC SURGERY	32.4	19.5	32.9	19.1	5	25.4	114.8
NEUROLOGICAL SURGERY	33.9	24.5	29.1	1.7	1.2	16.7	82.6
CARDIAC/THORACIC SURGERY	35.1	16.9	16.8	1.8	2.2	13.3	69.2
PEDIATRICS	25.4	13	19.5	10.5	1.6	8.2	65.2
OBSTETRICS/GYNECOLOGY	34	17.3	23.2	7.2	3.2	11.2	78.9
RADIATION ONCOLOGY	24	9.4	12.1	5.7	10.2	16	68
RADIOLOGY	19.8	10.5	14.2	4.6	7	21.8	67.4
PSYCHIATRY	6.9	5.1	10.5	0.4	0.3	7.3	25.5
ANESTHESIOLOGY	14.1	3.7	6.1	0.3	0.4	6	26.9
PATHOLOGY	21.2	10.4	11.4	6.4	2.1	21.5	62.8
DERMATOLOGY	51	28.3	31.8	12.5	4.6	16.6	116.4
EMERGENCY MEDICINE	6	15.1	1.8	0.8	0.1	11.5	32.7
NEUROLOGY	29.3	22.8	17.9	4.8	4.3	8.6	64.9
PHYS MED/RHEUMATOLOGY	39.2	24.1	32	5.8	4.7	12.2	93.9
OTHER SPECIALTY	23.1	13.6	20.5	4.4	1.8	9.5	59.3

*Clerical payroll is included in total non-physician payroll.							
**Total expenses exclude professional liability insurance premiums and employee physician payroll.							
Notes:							
(1) Only self-employed non-federal non-resident patient care physicians who responded to all relevant expense questions are included.							
Self-employed physician respondents with no practice expenses for the year are excluded.							
(2) Physicians whose typical number of hours worked in patient care activities per week is missing, less than 20, or equal to 168 are excluded.							
Physicians whose number of weeks worked the previous year is missing or less than 26 are excluded.							
(3) For each respondent, total practice expense and expense components per hour are calculated as (4) / (5) below.							
(4) Expenses adjusted for practice size = self-employed respondent expenses X # physician owners							
(5) Hours adjusted for practice size = (respondent hours * # physician owners) + (employee physician hours (see (6) below) * # employee physicians)							
(6) The typical number of hours worked in patient care activities for the employee physician(s) of a self-employed physician's practice is not known.							
Mean hours worked in patient care activities for employee physicians of each specialty are used as an estimate of employee physician hours.							
(7) As described earlier in this proposed rule, the practice expense per hour shown above reflect:							
- the "All Physician" supplies expense per hour for Oncology							
- use of supplemental practice expense data for Cardiac and Thoracic Surgery							
- removal of hours spent in Part A activities for Pathology.							
- Using the "All Physician" administration and other practice expense data for Emergency Medicine.							

• The Lewin Group also recommended that we revise edits and trims to the SMS survey data, both practice expenses and hours, to exclude data that fall outside set acceptable ranges (for example, three standard deviations from the geometric mean). We asked the AMA about their reaction to The Lewin Group's recommendation and the AMA replied:

> Trimming outlier values will further reduce sample size. Trimming expense values can also be problematic because high expense responses on the SMS are often justified when practice size and structure are taken into account. A trim may also disproportionately impact specialties with highly skewed distributions of PE-HR.

For this reason, we are not taking action in response to The Lewin Group's recommendation at this time.

• In addition, The Lewin Group recommended that we account for item non-response to questions related to practice expenses and patient care hours. We asked the AMA for their reaction to this recommendation as well. The AMA replied that they would need more information and added that there is no evidence that a pattern of non-response bias exists for practice expense, although it is a possibility. We are considering whether to study this issue further but, at this time, are not making any adjustments in response to this recommendation.

The report also makes suggestions on changes to the survey instrument used to collect practice expense data from practitioners. Though the original SMS survey does collect some information on practice expenses, it was not designed as a vehicle to calculate a specialty-specific practice expense per hour. We, and the contractor, have held several meetings with the AMA's SMS staff to discuss revisions to the survey that would help make our calculations more precise.

We understand that the AMA is currently piloting a new practice-level survey designed to address some of the limitations of the SMS. If the pilot of the survey is successful, we earlier understood that the AMA plans were to conduct the practice survey initially in CY 2000 and, in alternate years thereafter, the practice expense survey and the SMS survey. The AMA has recently indicated that its plans about the future of the SMS and collection of practice level survey data are unclear at this time. While the AMA has not made a final decision at this time about whether the practice level survey will be done, they have indicated concern to us about low response rates from the pilot test. Nevertheless, we are proceeding to make recommendations to the AMA regarding collection of practice expense data through the practice level survey. We will continue our discussion with the AMA regarding its plans for future practice expense data collection following completion of the practice level survey.

And, as we stated earlier, we believe these recommendations will be useful in the design of the practice level survey or any other survey of practice expenses used in developing RVUs for practice expenses.

The use of this practice level survey, as it is currently contemplated, responds to several of our contractor's recommendations. For example, it would address the recommendation that information be collected on each physician's percent share of practice expense and hours within the practice by collecting information at the total practice, rather than the individual physician owner level. The practice level survey also currently contains, as requested, questions on the number of hours the physician's office is open in a typical week and on the salaries for the mid-level practitioners used by the practice (that is, physician assistants, nurse practitioners, clinical nurse specialists, nurse mid-wives, certified registered nurse anesthetists, and physical and occupational therapists).

We are also suggesting additional changes in the survey questions or directions, generally reflecting our contractor's recommendations. We believe that the following changes would give more precise and reliable data on which to base our practice expense calculations:

- Emphasize the benefit of involving the practice manager or accountant in the completion of the survey and the need to

link the practice expense data to the practice's tax information whenever possible.

• Include a question concerning how many patient care hours are spent on uncompensated care, that is, care that the law requires one to provide, but for which one is not compensated. This would not include charity care that is voluntarily provided.

• Add a question concerning the amount or percentage of revenue generated by mid-level practitioners.

• Add a question concerning the amount or percentage of supply costs that relates to separately billable supplies (for example, drugs, casting supplies, and laboratory supplies).

• In addition, we are recommending that the survey include more specific questions on patient care hours and that separately billed mid-level practitioner hours be included.

The Lewin Group also recommended that the survey include questions about a typical week, rather than the most recent week. We are not adopting this suggestion because we believe that questions about the most recent week are likely to yield more concrete, accurate answers, whereas questions about a typical week are more likely based on estimates. As we have already stated, the AMA will no longer be collecting data through the SMS and the AMA has also expressed concern about low response rates from the pilot of the practice level survey. At this time,

we are unclear as to the AMA's plans with regard to future practice expense data collection efforts.

As we indicated earlier, we are currently proposing to use data from the 1998 SMS in developing the 2001 practice expense relative value units. Furthermore, data from the 1999 SMS will become available later this year. In addition, section 1848(c)(2)(B) of the Act requires that not less often than every 5 years, we review and make adjustments to RVUs. Thus, by law we are required to review and make adjustments to the practice expense RVUs no later than 2007. Regardless of whether the AMA continues to collect data on practice expenses, we will be developing plans for making refinements to practice expense RVUs beyond 2002.

We welcome comments on long-term strategies for refining the practice expense RVUs and any suggestions for how to collect practice expense data in the event it is no longer collected by the AMA. We will consider these comments and any further decisions by the AMA with regard to its practice expense data collection efforts in developing our refinement strategy beyond 2002.

(3) Direct Patient Care Hours

We have received many comments from specialty societies concerning our calculation of direct patient care hours. This is a major issue because the patient care hours are one half of the

ratio used to determine the practice expense per hour for each specialty. (The practice expenses of practitioners in a specialty are divided by the direct patient care hours in order to calculate the practice expense per hour). If the reported hours do not reflect the actual average billable hours for a specialty, the practice expense per hour will be over- or understated.

Several commenters representing surgical specialty societies have raised concern that the hours computed for their specialties have been overstated. This may be a result of SMS survey respondents including non-billable hours (such as stand-by time) when asked how many hours they worked each week. If this is the case, this would decrease the practice expense per hour for these specialties. In addition, commenters representing emergency room physicians raised the issue that the hours spent on uncompensated care were probably also included in the survey responses to the detriment of this specialty.

We agree with the commenters that there is a need to increase the level of confidence in the direct patient care hour data. We are already taking steps to improve the future accuracy of these data. As mentioned above, we are recommending that the future survey questions be worded more precisely so that only the appropriate practitioner hours are included. In addition, we have asked our contractor to give priority to recommendations on

steps we can take to improve the accuracy of the patient care hours.

As a first step in accomplishing this, The Lewin Group issued their second draft report on December 6, 1999, entitled "Validating Patient Care Hours Used in HCFA's Practice Expense Methodology." This report explores alternative methods that we might use to validate the time data collected by the SMS survey. The validation techniques attempt to achieve two goals: 1) identifying inaccurate existing data and 2) identifying inconsistencies in new data to be derived from future survey efforts.

The Lewin Group developed the following four validation techniques to analyze the SMS data used in computing the specialty-specific patient care hours:

- Method 1: Compare the patient care hour data reported at the beginning of the SMS survey (that asks for the total hours worked in a week) to responses from the detailed questions on patient care hours appearing later in the SMS survey.
- Method 2: Calculate ratios of SMS time pools to Harvard/RUC time pools by specialty, using Harvard/RUC procedure time data and Medicare claims data.
- Method 3: Compare newly reported SMS data to historical SMS data to identify outliers.

• Method 4: Compare SMS data on annual hours worked with annual hours data reported in the Medical Group Management Association's (MGMA) "Physician Compensation and Production Survey".

We have placed this report on our homepage under the title "Validating Patient Care Hours."

We agree with our contractor that no single validation approach exists that can be used to validate both existing and new data on patient care hours with a high level of confidence. However, the approaches described above, when used together, could be effective tools that will help to ensure the accuracy and reliability of existing and future data used in the calculation of practice expense RVUs. These validation efforts would allow us, and the medical community, to be more confident in the use of future data to update practice expense RVUs. Therefore, we extended The Lewin Group's contract so that, among other refinement tasks, the above analyses can be carried out. We are aware that even with the above initiatives, it might not be possible to address all concerns regarding refinement of the patient care hours in the short term. Therefore, we welcome any comments and suggestions as to other steps we could take to verify and improve the accuracy of the specialty-specific patient care hours.

(c) CPEP Data

(1) Relative Value Update Committee's Practice Expense Advisory Committee

The PEAC, a subcommittee of the RUC, held its initial meetings last year and the RUC made recommendations on CPEP inputs for clinical staff times, supplies, and equipment on approximately 65 CPT codes. We discussed our actions with regard to these recommendations in the November 1999 final rule. The PEAC continues to meet to refine the CPEP direct cost inputs, and we anticipate that we will receive additional RUC recommendations in July. We will address these recommendations in this year's physician fee schedule final rule.

In the November 1999 final rule, we deferred action on the RUC recommendations for a few groups of CPT codes on which we had significant questions. We are now proposing to accept the RUC recommendations with the revisions noted below:

Prostate Procedures

52647 Non-contact laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy

53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

We are accepting the total clinical staff time recommended for the in-office setting, but are moving 60 minutes from post to intra-service time for each of the above procedures because the staff time for observation of the patient during recovery from anesthesia belongs in the intra-service period. We are reducing the out of office preservice clinical staff time for CPT codes 52647 and 53852 to 30 minutes to match the RUC recommendation for CPT code 53850 and the time allotted in the office for each service and are making the out-of-office postservice time equal to the in-office postservice time because we believe there is no reason that these times should differ.

The supplies for all three procedures were adjusted to reflect three postoperative visits and to conform with the overall adjustment to supplies made in the November 1999 final rule. For CPT code 52647, we deleted the flexible cystoscope from the equipment because only one scope is required for the procedure. We also deleted the sterilizer because it is not typically used. For CPT code 53850, the RUC recommendations included the inputs for two different scenarios using two different devices. We chose what we believe to be the most typically used device and the inputs that accompany this. For CPT code 53852, we deleted the cystoscopes and sterilizer from

the equipment because we believe that they are not typically used.

Chemotherapy Procedures

96408 Chemotherapy administration, intravenous; push technique

96410 Chemotherapy administration, intravenous; infusion technique, up to one hour

The RUC had recommended 102 minutes of clinical staff time for CPT code 96408 and 121 minutes for CPT code 96410. In the November 1999 final rule, we solicited comments on these codes to assist us in our review. In response, the American Society of Clinical Oncology provided a breakdown by specific tasks of the above staff times. Included in this breakdown were 20 minutes for pre- and postprocedure education and 15 minutes for three phone calls after each visit.

Because we believe that the times for patient education and phone calls should be averaged over the whole course of chemotherapy treatment, and because there appeared to be some duplication in the pre- and postprocedure education tasks, we reduced both the patient education and phone call times by 5 minutes. Therefore, we are proposing 92 minutes of clinical staff time for CPT code 96408 and 111 minutes for CPT code 96410. For supplies, the specialty society agreed that we should delete

the silver nitrate stick and HEPA filters from both procedures and the infusion pump cassette from CPT code 96408.

(2) Clinical Staff Time

In the November 1999 final rule, we removed estimates of all clinical staff time allotted to the use of clinical staff in the facility setting from the CPEP data. Commenters have since noted that the clinical staff times reported by some CPEP panels for pre- and postservice times for 0-day global services performed in the office were recorded in the intra-service field in the CPEP database. These times were, therefore, deleted along with the times for the use of clinical staff in the facility setting, unlike the pre- and postservice times for 10 and 90-day global services that were entered into the separate pre and post data fields. The commenters argued that these pre- and postservice staff times for the relevant 0-day global services should be reinstated because these times are for staff in the office before and after the patient is in the facility.

We agree that these data are not comparable to the data we excluded for clinical staff used in the facility setting. We reviewed the "CPEP Recorders' Notes Files" compiled for each CPEP panel by Abt Associates, Inc., the contractor managing the CPEP panels. When the notes indicate that clinical staff estimates were for activities performed in physicians' offices, we are proposing to reinstate the time data for 0-day global services.

The fact that we have reinstated these time data does not mean that we necessarily agree that the amount of time assigned is correct. Like all the other raw CPEP data, these time data are subject to refinement and possible revision.

The entire recorders' notes file is available on our website and is entitled "CPEP Recorders' Notes Files." Addendum C shows a list of the codes for which pre- or postclinical staff time has been added, as well as the times that are now assigned.

(3) Supplies

In the November 1999 final rule (64 FR 59392), we indicated that casting materials are bundled into the payment for the initial fracture management procedures and that separate billing for the supplies is not allowed. However, commenters noted that our policy has been to allow separate payment for splints, casts, and other devices used for the reduction of all fractures and dislocations under section 1861(s)(5) of the Act. Since we provide separate payment for splints and casting supplies, we are now proposing to remove these types of expenses from practice expense inputs for all applicable fracture management and cast/strapping application procedure codes under the physician fee schedule.

In the November 1999 final rule, we deleted certain casting supplies (fiberglass roll, cast padding, and cast shoe) from the list of supplies for the casting and strapping CPT codes 29000

through 29750. We have identified additional CPT codes for the treatment of fractures/dislocations that have these supplies included in the CPEP data. Since these supplies are currently separately billable, we are proposing to remove the fiberglass roll, cast padding, and cast shoe from the following CPT codes: 23500 through 23680; 24500 through 24685; 25500 through 25695; 26600 through 26785; 27500 through 27566; 27750 through 27848; and 28400 through 28675.

In addition, we are also proposing to remove additional casting and splinting supplies from all the CPT codes referenced above because these supplies are also currently separately billable under section 1861(s)(5) of the Act. The list of supplies is as follows: stockingnet/stockinette; plaster bandage; Denver splint; dome paste bandage; cast sole; elastoplast roll; fiberglass splint; Ace wrap; Kerlix; Webril; Malleable Archbars; and elastics.

We welcome comments on whether these supplies should be deleted from additional procedures outside the code ranges referenced above, and whether we have appropriately identified all the casting supplies in our supply list.

(4) Equipment

We are currently using the original CPEP definitions for equipment that distinguish between "procedure specific equipment" and "overhead" equipment. The main distinction between the two

categories is that procedure specific equipment is used only for a limited number of procedures, while overhead equipment is used over a wide range of services. In terms of actual application, we assume a 50-percent utilization rate for procedure specific equipment, but a 100-percent rate for all overhead equipment. In addition, the methodology assumes that the procedure specific equipment is used only during the intraservice period, while it assumes that the overhead equipment is used for the entire service. We believe this distinction was more important under our original "bottom-up" methodology when the accuracy of the practice expense RVUs was almost totally dependent on the precision of the CPEP inputs. Under our current "top-down" methodology, however, when the CPEP inputs are used only as allocators of the specialty-specific practice expense pools, the distinction has served to hinder the process of refining the CPEP inputs while not leading to a substantive distinction in how we value services.

We are proposing to combine both categories of equipment into a single "equipment" category, assuming an average 50-percent utilization for all equipment. We believe that this will be beneficial to our refinement process for the following reasons:

- The current definition of the two categories of equipment necessitates many subjective decisions. While it might be

obvious that an examination table is used for a wide range of services and, therefore, would be overhead equipment, it is somewhat more arbitrary to classify equipment such as cystoscopes or specific x-ray machines as overhead or procedure specific.

- The various CPEP panels were not consistent in their application of the distinction between the two categories. Most of the items that were classified by some of the CPEP panels as overhead equipment were classified by another panel as procedure specific. In addition, equipment that would seem to be very similar was sometimes treated in different ways. For example, an examination table or a stretcher were considered to be overhead, but an electric table or a wheelchair were considered procedure-specific.

- It would simplify the refinement process to have only one category of equipment to consider rather than having to decide for all 7000 codes to which category each piece of equipment belongs.

We are also proposing to delete from the CPEP data equipment that is not used typically with any service, but is on "standby" for many services, or that is used for multiple services at the same time. In either of these cases, it is difficult to allocate the cost of this equipment appropriately to individual CPT codes. Examples of "standby" equipment are crash carts, defibrillators, wheelchairs, and stretchers. Examples of equipment used for

multiple procedures at the same time are cabinets, refrigerators, and autoclaves.

Following is the list of equipment that we are proposing to delete at this time from the CPEP inputs of all services: autoclave, wheelchair, refrigerator, film file cabinet, hazard material spill kit, embryo freezer, water system, flammable reagent cabinet, utility freezer, ultra low temperature freezer, acid cabinet, bulk storage refrigerator, abortion clinic security system, abortion clinic security guard, gomco suction machine, doppler, laser printer, lead shielding, defibrillator with cardiac monitor, blood pressure/pulseox monitor, blood pressure monitor, printer, crash cart--no defibrillator, and smoke evacuator.

The following is a list of equipment that we are proposing to delete as "standby" equipment for most codes, but that we believe typically may be used with a designated subset of procedures:

- X-ray view box--four panel (retain when currently in the CPEP data for codes in the range CPT codes 70010 through 79999).
- ECG machine--3 channel (retain when currently in the CPEP data for CPT codes 93000 through 93221).
- Pulse oximeter (retain when currently in the CPEP data for CPT codes 94620, 94621, 94680, 94681 and 94690; 94760 through 94770, 95807 through 95811 and 95819).

- ECG/blood pressure monitor--3 channel (retain when currently in the CPEP data for CPT codes 43200 through 43202 and 43234 through 43239).
- Cardiac monitor (retain when currently in the CPEP data for CPT codes 31615 through 31628).
- ECG-Burdick (except for HCPCS code G0166).

We welcome comments on this proposal and on any additional equipment that should not be considered a direct expense because the cost cannot appropriately be allocated to an individual service. Neither of these proposals to improve the CPEP equipment data have a significant impact on any specialty.

(5) CPEP Anomalies

In the November 1999 final rule, we made corrections to the CPEP data for a number of codes that we learned contained errors and anomalies that we could easily correct. Since that time, we have discovered some additional anomalies, and we are proposing to correct them at this time. As we stated in the final rule, though certain revisions may be made now, all practice expense inputs for these codes are still subject to further comment, refinement, and potential PEAC and RUC review and recommendations.

- We have identified several CPT codes that were not costed by the CPEP panels and were not assigned CPEP inputs. We are now crosswalking these services to the CPEP inputs of the most

appropriate other service. The CPEP inputs for these codes are subject to refinement. We welcome comments on the crosswalks that we have chosen. The codes and their crosswalks are shown below:

CPT and HCPCS Code		Crosswalk	
27347	Remove knee cyst	27345	Removal of knee cyst
28289	Repair hallux rigidus	28288	Partial removal of foot bone
31643	Diag bronchoscope/catheter	31629	Bronchoscopy with biopsy
36831	Av fistula excision	34111	Removal of arm artery clot
36833	Av fistula revision	36832	Av fistula revision
45126	Pelvic exenteration	58240	Removal of pelvis contents
57106	Remove vagina wall, partial	57110	Removal of vagina wall, complete
57107	Remove vagina tissue, part	57111	Remove vagina tissue, complete
59610	Vbac delivery	59400	Obstetrical care
59612	Vbac delivery only	59409	Obstetrical care
59614	Vbac care after delivery	59410	Obstetrical care
59618	Attempted vbac delivery	59410	Obstetrical care
59620	Attempted vbac delivery only	59514	Cesarean delivery only
59622	Attempted vbac after care	59515	Cesarean delivery
67220	Treatment of choroid lesion	67208	Treatment of retinal lesion
76831	Echo exam, uterus	76830	Echo exam, transvaginal
78206	Liver image (3d) w/flow	78205	Liver imaging (3D)

- The following services can be performed in the office, but either have no CPEP data for the office setting or have been assigned the same inputs as for the facility setting. Until these codes can be refined, we are proposing the following crosswalks for the in-office practice expense inputs so that costs in the office setting are appropriately reflected.

CPT Code		Crosswalk	
20225	Bone biopsy, trocar/needle	20220	Bone biopsy, trocar/needle
57105	Biopsy of vagina	57100	Biopsy of vagina (for intraservice period)

• Because the following either are not performed in the office setting or because we do not have appropriate CPEP inputs for the in-office setting for these services, we are designating the following CPT and HCPCS codes as "N/A" in the office setting: 99183 (Hyperbaric oxygen therapy); 21493 (Treatment of hyoid bone fracture); 21494 (Treatment of hyoid bone fracture with manipulation); 32997 (Total lung lavage); 33968 (Remove aortic assist device); 66830 (Removal of lens lesion); 69990 (Micro-surgery add-on); 92961 (Cardioversion, electric, internal) and we are designating G0167 (Hyperbaric oxygen treatment; no physician required) as carrier priced.

• The TC for CPT code 93660 (Tilt table evaluation) is carrier priced, but we are proposing to price it nationally. Therefore, we are reinstating the original CPEP data.

• We are crosswalking all CPEP inputs for CPT code 44201 (Laparascopy, jejunostomy) from the inputs for CPT code 44200 (Laparoscopy, enterolysis) to reflect that it is a 90-day global service.

• We are adjusting the CPEP inputs for CPT codes 15001 (Skin graft add-on); 15351 (Skin hemograft add-on); and 15401 (Skin heterograft add-on) to reflect that these are ZZZ services.

• CPT code 00103 (Anesthesia for blepharoplasty), which was not costed by the anesthesia CPEP panel, was inadvertently crosswalked to the CPEP inputs of two different CPT codes. We are deleting the crosswalk to the procedure CPT code 21450 and will retain the crosswalk to the anesthesia CPT code 00140 (Anesthesia for procedures on eye).

• We believe that the supply inputs for the retrobulbar injection codes (CPT codes 67500, 67505, and 67515) have been inappropriately crosswalked by the CPEP panel from adjacent surgical procedure codes. After consultation with an ophthalmology specialty society, we have adjusted the supplies so that the list now includes one alcohol swab, one pair of nonsterile gloves, one 5-cc syringe, and one 25-gauge needle.

• In several of the in-office ophthalmology codes, the supply list includes the costs for 50 to 100 sterile towels. The specialty society has confirmed that this is a typographical error and that the quantity should not exceed five for any one visit or procedure. We have made the appropriate adjustments.

• The supply list for CPT code 68761 (Close tear duct opening by plug), currently does not include the costs of a punctal plug. We have received a comment from the specialty

society representing optometrists requesting that we add this supply because it is typically used for this procedure. We agree with this comment and are proposing the addition of a punctal plug to the CPEP supplies. We have also deleted the inappropriate inputs from HCPCS code A4263, permanent tear duct plug.

• We have discovered a calculation error that affects the total cost of supplies for some of the codes for which the RUC made recommendations in 1999. We have made the appropriate corrections and are using the corrected values for this rule.

• We have adjusted the clinical staff and supply inputs for HCPCS code G0170, skin biograft, to reflect that it is a 10-day global service with one postprocedure visit.

After consultation with the specialty society, we have also adjusted the supplies for CPT code 53040, drainage of deep periurethral abscess, to correct for anomalies in the quantity of supplies between the in and out of office settings.

(d) Calculation of Practice Expense Pools--Other Issues

(1) Technical Refinement to Practice Expense Pools

The Act requires payment of some practitioner services (services of certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse mid-wives) based on a percentage of the physician fee schedule payment amount. Since the payment under

the physician fee schedule for a service performed by a midlevel practitioner is required to be based on a percentage of the amount paid to a physician for a service, we are proposing using only physician practice expense data in determining the practice expense RVUs for each practitioner service. Removal of the services performed by midlevel practitioners from the practice expense calculations would assist in simplifying the methodology and would also be consistent with the statutory requirement that we pay for their services based on a percentage of the fee schedule amount.

(2) Medicare Utilization Data

We have received comments from several surgical specialties urging us to evaluate the Medicare claims data to eliminate potential errors. (For example, claims for non-surgeons performing complex surgeries that are generally performed by surgical specialties only.) These commenters were concerned that incorrect specialty utilization will decrease a specialty's practice expense pool and recommended that these claims should either be reassigned to the appropriate specialty or excluded during refinement. To determine whether potential errors in the claim data have an adverse impact on any specialty or merely represent "noise" that creates no significant effect, we ran the following analyses:

First, we analyzed the utilization for CPT codes 63045 through 63048, the highest volume neurosurgical procedures performed by neurosurgeons. Our utilization data indicates that 91 percent of allowed services for these codes are performed by neurosurgeons and orthopedic surgeons. Of the 9 percent of allowed services when the utilization data indicates another specialty, 3 percent are attributed to general surgeons. An additional 2 percent are attributed to the HCFA specialty code for a clinic or other group practice, when it is likely that a surgeon who is a member of a multispecialty clinic is providing the surgical service. Of the remaining 4 percent of allowed services, the data indicates a specialty of general practice, family practice, or neurology.

For the utilization attributed to general and family practitioners, the data indicate that, in most cases, these physicians are serving as assistants-at-surgery. With respect to neurology (2 percent of the allowed services), we believe it is possible that a physician may practice as both a neurologist and neurosurgeon and designate neurology as the specialty for reporting on Medicare claims. For an insignificant percentage of the allowed services (under 1 percent of the allowed services for all remaining specialties combined), our data indicate a specialty that would not be expected to perform the neurosurgical procedure. In these cases, the incorrect CPT code might have

been transcribed on the Medicare claim or the incorrect specialty code may have been reported. There was a similar pattern for services associated with other surgical specialties.

We then tested the impact of reassigning to the dominant specialty this small proportion of allowed services associated with specialties not expected to perform them. We selected three of the specialties that commented on the possibility of erroneous utilization data and identified the complete range of specialized codes associated with each specialty. We reassigned to each dominant specialty the utilization currently assigned to other specialties not expected to perform the services. In addition, to test the "worst-case" scenario, we then crosswalked **all** frequencies for their complete range of codes to the selected individual specialty.

Neurosurgery

When we recoded CPT codes 61000 through 64999 to neurosurgery only, the impact on neurosurgery was a 0.55-percent increase. When we recoded the specialty for only those specialties that would not be expected to provide CPT codes 61000 through 64999 (specialties other than neurosurgery, orthopedic surgery, group practice or physician assistant) to neurosurgery, the resulting impact on neurosurgery was a 0.69-percent increase. In reviewing the utilization data for this code range, we found

services that are predominantly performed by radiologists and anesthesiologists (such as CPT code 62311). When we recoded only those services predominantly performed by neurosurgeons, the impact was even less.

Ophthalmology

When we recoded the specialty for all utilization in the range of CPT codes 65091 through 68899 to ophthalmology only, the impact on ophthalmology was 0.31 percent. When we recoded the specialty for only those specialties that would not be expected to provide CPT codes 65091 through 68899 to ophthalmology, the resulting impact on ophthalmology was a 0.32-percent increase.

Otolaryngology

When we recoded the specialty for all utilization in the range of CPT codes 69000 through 69979 to otolaryngology, the impact on otolaryngology was a -0.36 percent. When we recoded the specialty for only those specialties that would be expected to provide CPT codes 69000 through 69979 to otolaryngology, the resulting impact on otolaryngology was -0.35 percent.

We believe that these simulations exaggerate the potential impact of possible errors in the utilization data because, as discussed in the above analysis of CPT codes 63045 to 63048, our simulations likely reassigned the specialty in situations in which the specialty was correctly coded. In any case, in no

scenario did the impacts even approach a 1-percent increase or decrease.

We also believe these simulations demonstrate that the small percentage of potential errors in our very large database have no adverse effect on specialty-specific practice expense RVUs. Therefore, we are not proposing any further action at this time.

(3) Allocation of Practice Expense Pools to Codes

The Lewin Group has recently begun the third phase of the project. This phase will concentrate specifically on evaluating the indirect cost allocation methodology. They will evaluate the validity of our current methodology that allocates indirect costs using direct costs and work RVUs and consider alternatives to allocating indirect costs by the current method. The Lewin Group will perform a variety of tasks during this phase of the project to evaluate the advantages and shortcomings of our current indirect cost allocation methodology, as well as of any alternative methodologies. The preliminary tasks for Phase III include--

- Analyzing the current indirect cost allocation methodology to identify its advantages and shortcomings;
- Considering alternate ways in which our methodology might weight direct costs and work RVUs in the allocation of indirect costs and predicting the effects of these alternatives;

• Evaluating the impact and value of changing the methodology to use time rather than work measurements to allocate indirect costs;

• Interviewing experts in the field on potential alternatives to the current indirect cost allocation methodology; and

• Reviewing other relevant efforts to allocate indirect costs associated with physician and non-physician practice expenses.

The Lewin Group's draft final report will present the findings from all three phases of The Lewin Group's analysis of our practice expense methodology. As mentioned above, we are planning to extend The Lewin Group's contract for another year to obtain additional assistance on issues related to practice expense refinement.

(e) Site of Service

Clarifying the Definition of Facility/Nonfacility

For purposes of practice expense calculations, we make a distinction between services performed in a non-facility and a facility setting. This distinction takes into account the higher expenses of the practitioner in the non-facility setting when the practitioner typically bears the cost of the resources (for example, clinical staff, supplies, and equipment) associated with the services. In the facility setting, because these costs are

not incurred by the physician, Medicare payment to the facility includes the cost of the resources for the services furnished. The purpose of the distinction in the site-of-service is to ensure that Medicare does not duplicate payment, to the physician and the facility, for any of the practice expenses incurred in performing a service for a Medicare patient.

For purposes of applying the site-of-service differential, we are defining hospitals, skilled nursing facilities, and ambulatory surgical centers as facilities because they will receive a facility payment for their provision of services. We have been advised that community mental health centers (CMHCs) should also be defined as a facility setting since CMHCs also receive a separate facility payment for their services. Therefore, we are proposing to revise §414.22(b)(5)(i) (Practice expense RVUs) to add CMHCs to the settings listed in which we would apply the facility practice expense RVUs.

In addition, while we have indicated in previously published rules that the non-facility practice expense RVUs are applicable to outpatient therapy services (physical therapy, occupational therapy, and speech language pathology) furnished by comprehensive outpatient rehabilitation facilities or outpatient rehabilitation providers, there is confusion about this issue. Only the facility can bill for therapy services furnished to hospital and SNF patients. Because this facility payment must

include amounts reflecting practice expenses, the higher nonfacility RVUs are used to pay for therapy services even in the facility setting. Therefore, we would amend §414.22(b)(5)(i) to specifically provide that the nonfacility practice expense RVUs are applicable to outpatient therapy services regardless of the actual setting.

B. Geographic Practice Cost Index Changes

1. Background

The Act requires that payments vary among fee schedule areas according to the extent that relative costs vary as measured by the GPCIs. Generally, the fee schedule areas that existed under the prior reasonable charge system were retained under the fee schedule from calendar years 1992 to 1996. We implemented a comprehensive revision in fee schedule payment areas (localities) in 1997, reducing the number of localities from 210 to 89. A detailed discussion of fee schedule areas can be found in the July 2, 1996 proposed rule (61 FR 34615) and the November 1996 final rule (61 FR 59494). We are required by section 1848(e)(1)(A) of the Act to develop separate indices to measure relative cost differences among fee schedule areas compared to the national average for each of the three fee schedule components. While requiring that the practice expense and malpractice indices reflect the full relative cost differences,

the Act requires that the work index reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase in the adjustment over 2 years and implement only one-half of any adjustment in the first year if more than 1 year has elapsed since the last GPCI revision.

The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, and the second review was implemented in 1998. This constitutes the third GPCI review and revision and will be implemented in 2001.

2. Development of the Geographic Practice Cost Indices

The GPCIs were developed by a joint effort of researchers at the Urban Institute and the Center for Health Economics Research under contract to HCFA. Indices were developed that measured the relative cost differences among areas compared to the national average in a "market basket" of goods. In this case, the market basket consists of the resources involved with operating a private medical practice. The resource inputs are physician work or net income; employee wages; office rents; medical equipment, supplies; malpractice insurance; and other miscellaneous expenses. Employee wages, rents, medical equipment, supplies, and other miscellaneous expenses are combined to comprise the

practice expense component of the GPCI. The weights of these components in the original GPCIs (from 1992 through 1994), the first (1995 through 1997) and second (1998 through 2000) GPCI revisions, and the new weights for the third proposed GPCI revision (2001 through 2003) are as follows:

GPCI Component Weights

	1992 - 1994 GPCIs	1995 - 2000 GPCIs	2001 - 2003 GPCIs
Physician Work	54.2	54.2	54.5
Practice Expense	40.2	41.0	42.3
(Employee Wages)	(15.7)	(16.3)	(16.8)
(Rent)	(11.1)	(10.3)	(11.6)
(Miscellaneous)	(13.4)	(14.4)	(13.9)
Malpractice	5.6	4.8	3.2
	100.0	100.0	100.0

The resource inputs and their weights were obtained from the AMA's Socioeconomic Characteristics of Medical Practice Survey. The weights for the 1992 through 1994 GPCIs were from the AMA's 1987 survey, the latest available when the original GPCIs were being developed. The weights for the 1995 through 1997 and 1998 through 2000 GPCIs were from the 1989 survey. The 1989 weights are those used in the revised Medicare Economic Index (MEI) discussed in the November 25, 1992 final rule (Medicare Program; Revision of the Medicare Economic Index) (57 FR 55899). The

weights in the proposed 2001 through 2003 GPCIs are from the 1997 AMA survey and were used in the MEI revision discussed in November 2, 1998 final rule (Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1999) (63 FR 58846).

The MEI is a measure of annual increases in the cost of operating a private medical practice and is used in the annual update of the physician fee schedule CFs. Because the GPCIs and the MEI use the same resource inputs to measure the costs of a private medical practice (the GPCIs measure relative costs among areas while the MEI measures the national annual rate of increase in costs), we believe the same weights should be used.

Once the components and their weights were determined, data sources had to be found that were widely and consistently available in all physician fee schedule areas to measure costs. After examining many sources, the following proxies were selected as the best available sources for measuring each component of the original 1992 through 1994 GPCIs:

- Physician work--The median hourly earnings, based on a 20 percent sample of 1980 census data, of workers in six professional specialty occupation categories (engineers, surveyors, and architects; natural scientists and mathematicians; teachers, counselors, and librarians; social scientists, social

workers, and lawyers; registered nurses and pharmacists; writers, artists, and editors) with 5 or more years of college. Adjustments were made to produce a standard occupational mix in each area. The actual reported earnings of physicians were not used to adjust geographical differences in fees because these fees are, in large part, the determinants of the earnings. We believe that the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.

- Employee wages--Median hourly wages of clerical workers, registered nurses, licensed practical nurses, and health technicians were also based on a 20-percent sample of 1980 census data.

- Office rents--Residential apartment rental data produced annually by the Department of Housing and Urban Development (HUD) were used because there were insufficient data on commercial rents across all physician fee schedule areas.

- Miscellaneous expenses--The Urban Institute and the Center for Health Economics Research assumed that this component is represented by a national market and that costs do not vary appreciably among areas. This component's index is 1.000 for all areas to indicate no variation from the national average.

- Malpractice--Premiums in 1985 and 1986 for a mature "claims made" policy (a policy that covers malpractice claims made during the covered period) providing $100,000 to $300,000 of

coverage were used. Adjustments were made to incorporate the costs of $1 million to $3 million coverage and mandatory patient compensation fund requirements. Premium data were collected for physicians in three risk classes -- low-risk (general practitioners who do not perform surgery), moderate risk (general surgeons), and high-risk (orthopedic surgeons).

The areas selected for measurement purposes were the Metropolitan Statistical Areas (MSAs). Non-MSA areas within a State were aggregated into one residual area. Using MSAs for measurement satisfied the criteria of (1) homogeneity in resource input prices within the area, and (2) a size large enough so that market areas are self-contained to minimize border crossing; that is, physicians would not move their offices a few miles to secure higher payments and patients would tend to receive services within their area.

The Act requires, however, that the GPCIs reflect cost differences among fee schedule areas. Thus, it was necessary to map Medicare localities to the MSA and non-MSA aggregation of GPCI data. Where localities crossed MSA boundaries, MSA indices were converted to Medicare locality indices by population weights.

Detailed discussions of the methodology and data sources of the 1992 through 1994 GPCIs can be obtained by requesting the following studies from the National Technical Information Service

by calling 1-800-553-NTIS or, for residents of Springfield, Virginia, (703) 487-4650.

- The Urban Institute report "The Geographic Medicare Index: Alternative Approaches," NTIS PB89-216592.

- The supplement to "The Geographic Medicare Index: Alternative Approaches," NTIS PB91-113506. This was published in the September 4, 1990 notice for the model fee schedule (55 FR 36238).

- The Urban Institute report, "Refining the Malpractice Geographic Practice Cost Index," February 1991, NTIS PB91-155218. The related diskette is NTIS PB91-507491. This is the final version of the 1992 through 1994 GPCIs as published in the November 1991 final rule (56 FR 59785).

3. Revised 1995 through 1997 Geographic Practice Cost Indices

The main criticism of the original GPCIs was that they were outdated because they were based on old data; for example, 1980 census data and 1985 and 1986 malpractice premiums. This was, however, the most recent data available when the GPCIs were established. The revised 1995 through 1997 GPCIs were based on the most current data available when they were developed in 1993 and 1994.

We made some minor changes from the original GPCI methodology in calculating some of the revised 1995 through 1997 indices. One methodological change was made that applied across

all indices. As mentioned earlier, under the original GPCIs, where Medicare localities crossed MSA boundaries, MSA indices were converted to locality indices by population weights. Medicare expenditure weights were not used because the expenditures under the reasonable charge system contained large differences unrelated to relative cost differences among areas. In calculating the revised GPCIs, where localities crossed MSA boundaries, locality indices were calculated by weights based on the proportion of localities' RVUs provided in each MSA to reflect relative cost differences among areas. Full fee schedule RVUS were used rather than actual 1993 payments because 1993 fee schedule payments still reflected some reasonable charge payment levels. The advantages of RVU weighting are (1) the GPCIs more closely reflect physician practice costs in the area where the services are provided rather than where the population lives, and (2) budget neutrality is preserved when we combine multiple localities into larger areas, such as statewide localities.

a. Work Geographic Practice Cost Indices.

Data from the 20-percent sample of census data of median hourly earnings for the same six categories of professional specialty occupations as used in the 1992 through 1994 work GPCIs were used in calculating the 1995 through 1997 work GPCIs. The 1992 through 1994 work GPCIs were calculated using 1980 census data of earnings for professionals with 5 or more years of

college. That sample was no longer available with the 1990 census. The 1990 census educational classifications were by highest degree earned and not by years of schooling as in the 1980 census. Thus, it was not possible to obtain earnings data that exactly compared to the 1980 data.

For 1990, data were available for all-education and advanced-degree samples, but not for 5 or more years of college. We elected to use the all-education sample because its larger sample sizes made it more stable and accurate in the less populous areas. Although it could be argued that physicians' earnings might more closely approximate the earnings of professionals with advanced degrees, the differences between the all-education and advanced-degree indices were negligible in all but a few of the smallest localities. We believed that the small sample sizes of advanced-degree occupations in these small localities may produce inaccurate results.

The 1992 through 1994 work GPCIs used metropolitan-wide median wages for each county within an MSA. That is, all counties within an MSA were assigned the MSA-wide median wage even if there were wage variations within the MSA. We believed that this was appropriate for all but Consolidated Metropolitan Statistical Areas (CMSAs), the largest of the MSAs, such as New York. In these CMSAs, we replaced metropolitan-wide earnings with county-specific earnings. We believed this change was

appropriate because costs were, in fact, higher in central city areas (for example, Manhattan and San Francisco) than in the rest of the CMSA. County earnings better account for cost variation within these large metropolitan areas.

b. Practice Expense Geographic Practice Cost Indices.

(1) Employee Wage Indices.

Data from the 20-percent sample of census data of median hourly earnings for the same categories of medical and clerical occupations used in the 1992 through 1994 practice expense GPCIs were used in the 1995 through 1997 practice expense GPCIs. The 1995 through 1997 practice expense GPCIs used 1990 rather than 1980 census data. As with the work GPCIs, county level data were used for CMSAs to better reflect the cost variations within these large metropolitan areas.

(2) Rent Indices.

As with the original rent indices, the HUD fair market rental (FMR) data for residential rents were again used as the proxy for physician office rents. The 1995 through 1997 practice expense GPCIs reflect 1994 HUD FMRs. Like the work GPCI and the employee wage index of the practice expense GPCIs, county level data were used in CMSAs to recognize the variations within the CMSA.

The major criticism of the rent indices was that residential rather than commercial rent data were used. As mentioned earlier, for constructing the GPCIs, we needed data that were widely and consistently available across all physician fee schedule areas. As with the original GPCIs, we again searched for private sources of commercial rent data that were widely and consistently available.

The private sources we found were not adequate. None of the sources collected data for nonmetropolitan areas, nor did any collect data for all metropolitan areas. The sources did not reflect the average commercial space in the area, but rather the particular type of space most relevant to the needs of a particular source's clients. In addition, the sample sizes were small. A comparison of the average rental for any particular city showed significant variation depending upon the source. Also, the private commercial rent data tended to be for very high priced real estate of the type likely to be used by large institutions such as banks, insurance companies, or financial firms and not for the type of office space used by physicians.

Among the sources of commercial rent data available, the most promising were data from the Building Owners and Managers Association, the General Services Administration, and the U.S. Postal Service. These data were analyzed in depth. We did not use data from the Building Owners and Managers Association

and the General Services Administration because of poor geographic coverage, especially outside of large metropolitan areas. That is, data were not widely and consistently available for all physician fee schedule areas. The U.S. Postal Service data had much better geographic coverage, but sample sizes in many areas were unacceptably small and could have led to erroneous results.

No acceptable national commercial rent data are readily available for physician office rents. Thus, some proxy must be used for this portion of the index. In addition, commercial rent data are not available for all areas from published statistical sources.

We believe that the HUD FMR data remain the best available data for constructing the office rental index. They are available for all areas, are updated on an annual basis, and are consistent among areas and from year to year. Moreover, physicians are frequently located in areas and office space that are residential rather than commercial (for example, in apartment complexes and small strip commercial centers adjacent to residential areas).

(3) Medical Equipment, Supplies, and Miscellaneous Expenses.

As mentioned earlier, the GPCI assumes that this component has a national market and that input prices do not vary among geographic areas. We were unable to find any data sources that

demonstrated price differences by geographic area. Anecdotal and interview data from suppliers and manufacturers were inconclusive. While some price differences may exist, they are more likely to be based on volume discounts rather than on geographic areas. Generally, it appears that manufacturers' prices do not vary among areas except for shipping costs. Since manufacturers and suppliers are located all over the country, shipping costs on the mainland do not vary significantly.

We did consider an add-on for shipping costs to Alaska, Hawaii, and Puerto Rico to recognize the added shipping distance. We decided against the add-on because there were no data to indicate how much the costs of shipping medical equipment and supplies to these areas increased their total costs. We were able to ascertain that commercial shippers like United Parcel Service and Federal Express generally charge about 10 percent more to ship to Puerto Rico and about 20 percent more to ship to Alaska and Hawaii from the mainland.

Medical equipment and supplies represent about 7 percent of physician practice costs. Even assuming that shipping costs represent 5 percent of total equipment and supply costs, which we believe to be a high estimate, recognizing a 20 percent increase in shipping costs would only increase payment levels by 0.07 percent or 0.0007 (.20 x .05 x .07 = .0007). The medical equipment, supplies, and miscellaneous expense index for all

areas continued to be 1.000 in the revised 1995 through 1997 GPCIs.

c. Malpractice Geographic Practice Cost Indices.

Again, malpractice premium data for a $1 million to $3 million mature "claims made" policy were collected, with mandatory patient compensation funds considered. However, more recent and more comprehensive malpractice insurance data were used in calculating the 1995 through 1997 malpractice GPCIs. The 1995 through 1997 malpractice GPCIs were based on 1990 through 1992 premium data. Malpractice premiums are very volatile and may change significantly from year to year. We decided to use the most recent 3-year average available rather than just the most recent single year to smooth out this volatility and present a more accurate indication of malpractice premium trends over time.

We collected data on more specialties and from more insurers. We collected data on 20 specialties, rather than on only three as in the 1992 through 1994 malpractice GPCIs. The 1992 through 1994 malpractice GPCI data were largely drawn from a single nationwide insurer (St. Paul Fire and Marine) and were supplemented by several State-specific carriers in States in which St. Paul did not offer coverage. Subsequent analyses suggest that these data were not representative of insurers operating in many States. For the revised malpractice GPCI, data

were collected from insurers that, on average, represented 82 percent of the market in each State, with the lowest State market share being 60 percent. We believe that the more recent and much more comprehensive data greatly improved the accuracy of the malpractice GPCIs for 1995 through 1997.

Detailed discussions of the methodology and data sources of the 1995 through 1997 GPCIs can be obtained by requesting the following studies from NTIS by calling 1-800-553-NTIS, or (703) 487-4650 in Springfield, Virginia:

- "Updating the Geographic Practice Cost Index: Revised Cost Shares." Debra A. Dayhoff, John E. Schneider, and Gregory C. Pope. NTIS PB94-161072.
- "Updating the Geographic Practice Cost Index: The Physician Work GPCI." Gregory C. Pope and Deborah A. Dayhoff. NTIS PB94-161080.
- "Updating the Geographic Practice Cost Index: The Practice Expense GPCI." Gregory C. Pope, Deborah A. Dayhoff, Angella R. Merrill, and Killard W. Adamache. NTIS PB94-161098.
- "Updating the Geographic Practice Cost Index: The Malpractice GPCI." Stephen Zuckerman and Stephen Norton. NTIS PB94-161106.

4. Revised 1998 through 2000 Geographic Practice Cost Indices

The same data sources and methodology used for the 1995 through 1997 GPCIs were used for the revised 1998 through 2000 GPCIs with a few very minor modifications. No acceptable additional data sources were found. The cost shares were the same as in the 1995 through 1997 GPCIs because no changes were made in the MEI weights.

Indices for fee schedule areas are based on the indices for the individual counties within the fee schedule area. Fee schedule RVUs are again used to weight the county indices (to reflect volumes of services within counties) when mapping to fee schedule areas and in constructing the national average indices. However, we used more recent data, 1994 rather than 1992 RVUs, in the county, locality, and national mapping in the proposed GPCIs. The payment effect of this is negligible in most cases and generally results in changes at the third decimal point if at all.

a. Work Geographic Practice Cost Indices.

The work GPCIs are based on the decennial census. The 1992 through 1994 work GPCIs were based on 1980 census data because 1990 census data were not yet available. The work GPCIs were revised in 1995 with new data from the 1990 census. New census data will not be available again until after the 2000 census. We searched for other data that would enable us to update the work

GPCIs between the decennial censuses but no acceptable data sources were found. The most promising sources of data were the hospital wage data that we collected to calculate the prospective payment system (PPS) hospital wage index and the payroll per worker data collected by the U.S. Bureau of Labor Statistics from State unemployment insurance agencies ("the ES-202 data").

The PPS hospital wage data were examined when we constructed the original GPCIs. They were rejected in favor of census data because of their lack of an occupation mix adjustment and their unrepresentative occupational composition (hospital employees rather than professionals or physician office employees). ES-202 data consist of total payroll divided by counts of wage and salary workers. Their major disadvantages were that they did not measure hourly earnings, only payroll per employee, and no occupational detail is available. Also, they did not adjust for part-time or full-time and hours worked, and the numbers of workers are small for certain States, leading to unstable estimates of payroll per worker. We compared the changes by State from 1989 to 1993 in the PPS wage data and the ES-202 data to see if there was any correlation between the two series. The correlation between the two was only moderate: 0.55. The changes indicated by both series were generally small, for example, a few percentage points. The difference between the two series by State was in many cases as large as, or greater than, the change

indicated by either series. The average difference between the two series (2.1 percent) is as large as the change indicated by either series. In addition, changes for particular States were substantially different between the two series. For example, Indiana relative wages rose by 1.9 percent according to the PPS data, but fell 5.7 percent according to the ES-202 data.

Since we were unable to find an acceptable data source for updating the work GPCIs, we examined the consequences of not updating the work GPCIs between the decennial censuses. We compared the changes between the 1992 through 1994 work GPCIs, based on the 1980 census and the 1995 through 1997 GPCIs, based on the 1990 census. On average, the full variation State work GPCIs changed by about 5 percent. This translates to about a 1.2 percent change in the quarter work GPCI required by law. Since work makes up about one-half of the GPCI cost shares, this translates into an average payment change per State of about 0.6 percent from updating the work GPCI based on the 10-year change in relative wages indicated by the census data. Even the maximum change in the full variation State work GPCIs from the 1992 through 1994 to the 1995 through 1997 GPCIs of 14 percent translates into only about a 1.8 percent change in payments. The largest full work GPCI changes for individual payment areas were from 16 to 20 percent, or about a 4 to 5 percent change in the quarter work GPCI, or about a 2.4 percent change in payments.

However, 80 percent of payment areas experienced payment changes of less than 1 percent, and 50 percent of payment localities experienced payment changes of less than 0.5 percent as a result of changes in the census data from 1980 to 1990.

We, therefore, made no changes in the 1998 through 2000 work GPCIs from the 1995 through 1997 work GPCIs, other than the generally negligible changes resulting from using 1994, rather than 1992, RVUs for this GPCI update because we were unable to find acceptable data for use between the decennial censuses. We believe that making no changes is preferable to making inaccurate changes based on unacceptable data. We believe that this is a reasonable position given the generally small magnitude of the changes in payments resulting from the changes in the work GPCIs from the 1980 to the 1990 census data.

b. Practice Expense Geographic Practice Cost Indices.

(1) Employee Wage Indices.

As with the work GPCIs, the employee wage portion of the practice expense GPCIs is based on decennial census data. For the same reasons discussed above pertaining to the work GPCIs, we made no changes in the employee wage indices during the 1998 through 2000 GPCI update. The average change from the 1992 through 1994 to the 1995 through 1997 employee wage indices across States was about 6 percent. Since the employee wage index

had a weight of about 16 percent in the GPCI cost shares, this translated into a 1 percent average change in payments. The maximum payment change in any payment area resulting from changes from the 1992 through 1994 to the 1995 through 1997 employee wage indices was about 3.2 percent. Payment changes in over two-thirds of the payment areas were less than 1 percent.

(2) Rent Indices.

The office rental indices were again based on HUD residential rent data. The rental indices were based on 1996 HUD data as opposed to the 1994 HUD data in the 1995 through 1997 GPCIs. HUD made two small methodological changes in developing the data. First, HUD used the 40th percentile of area rents rather than the 45th percentile. This did not materially affect the GPCIs, which measure relative rents among areas. Second, HUD established a rental floor for rural counties at the statewide rural average. This had the effect of raising the office rental indices slightly in rural areas.

We made one methodological change in the rent indices. HUD publishes FMRs only for metropolitan areas as a whole. For the 1995 through 1997 GPCIs, HUD used a special tabulation of the 1990 census data to allocate rents by county within CMSAs. In some metropolitan areas, this had the effect of reducing the central city index below the suburban index, probably because of lower unmeasured housing quality in central cities than in

suburbs. This may not have been the best indicator of relative physician rents, since the GPCIs are intended to measure rental costs for offices of similar quality in different areas. The metropolitan-wide rent is most appropriate for measuring the cost of space of an average quality across the metropolitan area, which is why HUD publishes only metropolitan-wide FMRs. Also, the census county adjustments can be updated only once every 10 years. For this reason, we believed that the county-specific adjustment should not be made for all large metropolitan areas, but should be retained only for the New York City Primary MSA. Available evidence suggested that rents vary substantially among the boroughs of New York City and that, given the current locality configuration, the county-specific rental adjustment appropriately reflected these patterns in the New York City area, especially the higher rents in Manhattan.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses.

As with the 1992 through 1994 and 1995 through 1997 GPCIs, this component was given a national value of 1.000, indicating no measurable difference among areas in costs.

c. Malpractice Geographic Practice Cost Indices.

Again, malpractice premium data were collected for a mature "claims made" policy with $1 million to $3 million limits of coverage, with adjustments made for mandatory patient

compensation funds. As with the 1995 through 1997 GPCIs, data were collected for the 20 largest Medicare-billing physician specialties. The premium data represent at least 50 percent of the market in each State. Again, we used an average of the 3 most recent premium years to smooth out the considerable year-to-year fluctuations that can occur in malpractice premiums. The revised 1998 through 2000 malpractice indices were based on 1992 through 1994 premium data, the latest years available when the Health Economics Research (HER) GPCI study was being conducted in 1995 through 1996. Another change from the 1995 through 1997 indices is that we weighted the specialty shares of the 20 specialties by fee schedule RVUs rather than allowed charges.

Detailed discussions of the methodology and data sources of the 1998 through 2000 GPCIs may be obtained by requesting the following study from NTIS by calling 1-800-533-NTIS, or, for residents of Springfield, Virginia, (703) 487-4650: "Second Update of the Geographic Practice Cost Index." Gregory C. Pope and Killard W. Adamache.

5. Proposed 2001 through 2003 Geographic Practice Cost Indices.

We propose using the same data sources and methodology used for the 1998 through 2000 GPCIs for the 2001 through 2003 GPCIs (hereafter referred to as proposed GPCIs). No acceptable additional data sources were found. The only differences between the 1998 through 2000 GPCIs and the proposed GPCIs are in the

cost shares and RVU weighting. As shown in the cost share table in the discussion of the development of the GPCIs, the cost shares have been changed to reflect the revisions in the MEI. This does not affect the work or malpractice GPCIs since they are stand-alone indices. The change has a small effect on the practice expense GPCIs because it changes slightly the weights among the employee wage, rents and miscellaneous components of the practice expense index. We used more recent RVU data -- 1998 rather than 1994 -- in the county, locality, and national mapping in the proposed GPCIs. The payment effect of this is generally negligible.

a. Work Geographic Practice Cost Indices.

For the same reasons discussed in the section on the 1998 through 2000 work GPCIs, no significant changes are being proposed in the 2001 through 2003 work GPCIs because we were unable to find acceptable data for use between the decennial censuses. There are general negligible changes resulting from the use of 1998 rather than 1994 RVUs for weighting.

b. Practice Expense Geographic Practice Cost Indices.

(1) Employee Wage Indices.

As with the work GPCIs, the employee wage indices are based on decennial census data. For the same reasons discussed above

pertaining to the work GPCIs, we are proposing no changes in the employee wage indices during this GPCI update.

(2) Rent Indices.

The office rental indices are again based on HUD residential rent data. No changes have been made in the methodology. The proposed rental indices are based on 2000 rather than 1994 HUD data.

The proposed rental indices are compared to the current rental indices in Addendum D. A reduction in an area's rent index does not necessarily mean that rents have gone down in that area since the last GPCI update. Since the GPCIs measure area costs compared to the national average, a decrease in an area's rent index means that an area's rental costs have decreased when compared to the change in national average rental costs. The indices are arranged in descending order of change. The rental index has a cost share of about 12 percent of the GPCI. This means that the actual effect on payments will be about 12 percent of the change in the rental indices. While the new rental indices show significant changes in a few areas, primarily in the San Francisco Bay area, 80 of the 89 areas change by less than 10 percent, which translates into about a 1 percent change in payments.

(3) Medical Equipment, Supplies, and Miscellaneous Expenses.

As with all previous GPCIs, this component would be given a national value of 1.000, indicating no measurable differences among areas in costs.

c. Malpractice Geographic Practice Cost Indices.

We propose using the same methodology described in the 1998 through 2000 malpractice GPCI section in the proposed malpractice GPCIs for 2001 through 2003. The only difference is that we used more recent data. The proposed malpractice indices are based on 1996 through 1998 data compared to the 1992 through 1994 data used in the previous GPCI update.

Addendum E shows the changes from the 1998 through 2000 indices to the proposed malpractice GPCIs. A change in an area's malpractice GPCI does not mean that absolute malpractice premiums have changed by that amount. It, rather, reflects the area's new position compared to the national average. As with past GPCI revisions, the changes in the proposed malpractice GPCIs are relatively large in some cases, reflecting the significant changes in malpractice premiums that occur from year to year. As Addendum E shows, two-thirds of the payment areas experience changes of less than 12 percent. It should be noted, however, that the weight of the malpractice GPCI is only about 3 percent of the total GPCI. Therefore, a 12 percent change in the malpractice GPCI translates into only a 0.4 percent change in payments. Even the largest 42 percent change in the malpractice

GPCI translates into only a 1.3 percent change in payments. The mean change in the malpractice GPCIs is 11 percent, or about a 0.4 percent change in payments.

The proposed 2002 fully-effective revised GPCIs and the transitional 2001 revised GPCIs can be found at Addendum F and Addendum G, respectively. Since the proposed revised GPCIs could result in total payments either greater or less than payments that would have been made if the GPCIs were not revised, it was necessary to adjust the GPCIs for budget neutrality as required by law. Therefore, we adjusted the 2001 through 2002 GPCIs as follows: work by 0.99699; practice expense by 0.99235; and malpractice by 1.00215.

C. Resource-Based Malpractice Relative Value Units

In the July 1999 proposed rule (64 FR 39610) and the November 1999 final rule (64 FR 59383) for the CY 2000 physician fee schedule, we discussed the methodology used to calculate resource based malpractice RVUs and proposed interim RVUs effective January 1, 2000. (See "Legislative History" section for dates and **Federal Register** citations for these rules.) The methodology can be briefly summarized as follows:

- Actual malpractice premium data were collected for the top 20 Medicare physician specialties.

• All Medicare specialties were mapped to insurer rating classes (ISO codes).

• A national average premium was calculated for every specialty.

• Specialty risk factors showing the relative malpractice costs among specialties were created by dividing each specialty national average premium by the lowest average premium.

• Specialty-weighted malpractice RVUs were calculated for each procedure by summing, for all specialties providing the procedure, the product of each specialty's risk factor times the proportion of total service count for that procedure provided by the specialty.

• This number was multiplied by the procedure's work RVUs to account for differences in risk-of-service among procedures.

• The new malpractice RVUs were adjusted by the appropriate factor to attain budget neutrality.

The malpractice RVUs were based on 1993 through 1995 premium data, the most recent premium data readily available. In last year's proposed and final rules we stated that we planned to collect more recent data, but did not expect that newer data would change the values significantly since malpractice premiums have been remarkably stable in recent years.

We have now obtained, and are currently examining, malpractice premium data for 1996 through 1998. The malpractice

RVUs in the fall final rule will reflect the newer data. While we have not yet completed the proposed malpractice RVU calculations, the table below compares the 1993 through 1995 average premiums (that were used to calculate the 2000 malpractice RVUs) with the 1996 through 1998 average premiums (that will be used to calculate the 2001 malpractice RVUs). As the table below shows, there was very little change in the national average premiums from 1993 through 1995 to 1996 through 1998. We, therefore, anticipate minimal changes in malpractice RVUs from use of the more recent data.

National Average Premiums By Surveyed Specialties

ISO	Specialty	1996 avg	1997 avg	1998 avg	93-95	96-98	Trend
80114	Ophthalmology	11,304	11,377	10,945	10,960	11,209	0.75%
80143	General surgery	27,667	28,116	27,694	27,020	27,825	0.98%
80144	Thoracic surgery	39,056	39,020	38,359	38,789	38,812	0.02%
80145	Urology	16,799	17,163	16,911	15,817	16,958	2.35%
80151	Anesthesiology	15,708	15,468	14,904	17,231	15,360	-3.75%
80152	Neurosurgery	58,104	58,263	56,735	54,610	57,701	1.85%
80154	Orthopedic surgery	39,182	38,882	37,688	38,877	38,584	-0.25%
80156	Plastic surgery	31,670	31,708	31,062	30,599	31,480	0.95%
80159	Otolaryngology	20,603	19,845	19,521	19,748	19,990	0.41%
80244	Gynecology	8,445	8,690	8,790	n/a	8,642	n/a
80249	Psychiatry	6,645	6,533	6,664	7,240	6,614	-2.96%
80269	Pulmonary disease	9,352	9,553	9,620	8,594	9,508	3.42%
80274	Gastroenterology	11,691	11,890	11,655	11,008	11,745	2.18%
80280	Diagnostic radiology	12,099	12,651	12,365	10,783	12,372	4.68%
80281	Cardiology	13,265	13,367	12,980	12,465	13,204	1.94%
80282	Dermatology	10,690	10,865	10,394	10,946	10,650	-0.91%
80284	Internal medicine	11,770	11,941	11,798	11,491	11,836	0.99%
80288	Neurology	14,000	13,758	13,421	12,396	13,726	3.45%
80292	Pathology	9,633	9,690	9,439	8,913	9,587	2.46%
80423	General practice	11,181	11,354	11,167	10,465	11,234	2.39%
n/a -data not available							

In addition, in response to comments received on last year's rules, we are proposing to accept a comment regarding crosswalking specialties. We are proposing to crosswalk surgical oncology to general surgery rather than to all physicians. The malpractice values to be included in the final rule reflecting the updated data will remain interim.

D. Critical Care Relative Value Units

In the November 1999 final rule (64 FR 59423), we established interim work RVUs for CPT codes 99291 and 99292 (critical care services) of 3.6 and 1.8, respectively, which were

decreased from the previous RVUs for these services. These work RVUs were established because of the change in the CPT definition of critical care services in CPT 2000. We also discussed in detail what changes in the definition most concerned us. We received many comments on the interim work RVUs for critical care.

This year we proposed new coding language to the AMA CPT Editorial Panel (the Panel) to resolve physician concerns. The Panel, with input from various specialty societies, accepted the language that we proposed with some modifications. The AMA has given us copyright permission to publish the introduction for CPT codes 99291 and 99292 as it will appear in CPT 2001. For CPT 2001, the introduction for critical care services will be as follows (new language in bold):

> Critical care is the direct delivery by a physician(s) of medical care for a critically ill or **critically** injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that **there is a high probability of imminent or life threatening deterioration in the patient's condition**. Critical care involves decision making of high complexity, to assess, manipulate, and support **vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to**: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic **and/or** respiratory failure. **Although critical care typically requires** interpretation of multiple **physiologic parameters and/or** application of advanced technology**(s)**, **critical care may be provided in life**

threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Critical care services provided to infants older... *(no change to this paragraph)*

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561,93562), chest x-rays (71010, 71015, 71020), **pulse oximetry (94760, 94761, 94762)**, blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data (99090); gastric intubation (**43762**, 91105); temporary transcutaneous pacing (92953); ventilator management (94656, 94657, 94660, and 94662); and vascular access procedures (36000, 36410, 36415, **36540** and 36600). Any services performed which are not listed above should be reported separately.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any

given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time

Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether the time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medial staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patients condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation **bears directly on the management of the patient.**

Time spent in activities that occur outside of the unit or off the floor (eg, telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (eg, participation in administrative meetings or telephone calls to discuss other patients). **Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.**

The remainder of the introduction as published in CPT 2000, as well as the descriptors for the two CPT codes (99290 and 99291), remains unchanged.

Adoption of this revised introduction for the critical care CPT codes 99291 and 99292 is consistent with our view of the appropriate intensity of these services and addresses the concerns we had raised in the November 1999 final rule. Therefore, based on implementation of this revised introduction for critical care services for CY 2001, we are proposing to value the physician work at 4.0 RVUs for CPT code 99291 and 2.0 RVUs for CPT code 99292.

In addition, consistent with our discussion in the proposal for electrical bioimpedance (EB) (see section II.H), we are proposing to not allow separate Medicare payment for EB when provided in conjunction with critical care services (CPT codes 99291 and 99292).

E. Care Plan Oversight and Physician Certification/Recertification

The Panel considered changes to the definition of care plan oversight for 2001. After analyzing the definition changes, we are concerned that these codes (CPT codes 99375 and 99378) will no longer be consistent with our coverage criteria.

In anticipation of the likely CPT revisions, we would establish two new HCPCS codes for care plan oversight that are consistent with our coverage criteria. For the 2001 physician fee schedule, we would establish a new HCPCS code Gxxx1, that will use the CPT 2000 definition associated with CPT code 99375 and a new HCPCS code Gxxx2, that will use the CPT 2000 definition associated with CPT code 99378. The current policy guidance that applied to CPT codes 99375 and 99378, including our past responses to questions on care plan oversight, will continue to apply to these G codes. The current payments for CPT codes 99375 and 99378 will be maintained in Gxxx1 and Gxxx2.

In addition, we would establish two new HCPCS codes (Gxxx3 and Gxxx4) to describe the services involved in physician certification (and recertification) and development of a plan of care for a patient for whom the physician has prescribed Medicare-covered home health services. The proposed text of the new codes will read as follows:

Gxxx3 Physician services for initial certification of Medicare-covered services by a home health agency, per patient’s home health certification period

This code would be used when the patient has not received Medicare-covered home health services for at least 60 days.

Gxxx4 Physician services for recertification of Medicare-covered services by a home health agency, per patient's home health certification period

This code would be used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period.

The use of these HCPCS codes (Gxxx3 and Gxxx4) would be restricted to physicians who are permitted to certify that home health services are required by a patient pursuant to section 1814(a)(2)(C) and section 1835(a)(2)(A) of the Act. The Gxxx3 code would be billed only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode. Consistent with section 1835(a)(2) of the Act, a physician who has a significant ownership interest in, or a significant financial or contractual relationship with a home health agency (HHA), generally cannot bill this code for patients served by that HHA.

For services within the episode (generally beyond the first week or two of care plan implementation) that are consistent with the definition of care plan oversight (HCPCS code Gxxx1), the care plan oversight code (CPT code 99375) would be used.

Because we believe that the physician work associated with HCPCS code Gxxx3 equates to that of a level 3 established patient office visit (CPT code 99213), we are proposing a value of .67 for the work RVUs. For Gxxx4, because we believe the work equates to a level 2 established patient office visit (CPT code 99212), we are proposing a value of .45 for the work RVUs. For practice expense RVUs, we are proposing to crosswalk both Gxxx3 and Gxxx4 to the practice expense inputs currently used for care plan oversight (CPT code 99375).

F. Observation Care Codes

In 1998, the AMA added new CPT codes 99234 to 99236, Observation or inpatient hospital care services (including the admission and discharge services) for a patient on the same date. We accepted the RUC recommendations for work RVUs for these new codes. The work RVUs for each code are the sum of the applicable admission work for CPT codes 99218 to 99220 (or CPT codes 99221 to 99223) plus the discharge work (CPT codes 99217 or 99238). For example, CPT code 99234 has 2.56 work RVUs, which is the sum of the work RVUs for CPT code 99221 (1.28) plus the work RVUs for CPT code 99217 (1.28). However, it has come to our attention that allowing payment for these CPT codes conflicts with two policies currently in the Medicare Carrier Manual (MCM).

Section 15505.1(c) of the MCM states that we will pay for only the initial hospital care service code when a patient is

admitted as an inpatient and discharged on the same day. Physicians are not paid for both an inpatient hospital admission and hospital discharge management on the same day. In addition, section 15504.b of the MCM instructs that CPT codes 99218 to 99220 (Initial observation care) should be used if the patient is discharged on the same day as the admission for observation because each of these codes represents a full day of care and, thus, paying for a code representing both admission and discharge on the same day would be duplicative. CPT code 99217 (Observation care discharge) may be billed only on the second or subsequent days in observation.

These two payment policies result in different payments for patients whose inpatient stay is less than 24 hours based solely on whether they were in the hospital at midnight. For example, a physician who admits a patient to observation or to inpatient care at 8 a.m. and then discharges the patient at 8 p.m. the same day, would be allowed payment for only the admission service. On the other hand, a physician who admits a patient to observation or to inpatient care at 8 p.m. and then discharges the patient at 8 a.m. the next day, would be allowed payment for both the admission and discharge services.

In response to these concerns, and to clarify our payment policy, we are proposing the following:

Inpatient stay of 24 hours or more - We would pay for both inpatient hospital admission services (CPT codes 99221 to 99223) and hospital discharge services (CPT codes 99238 to 99239) when a patient is a hospital inpatient for a period of 24 hours or more. The medical record must document that the patient was an inpatient for at least 24 hours for both of these services to be paid.

Inpatient or observation stay of less than 8 hours - If a patient is admitted as a hospital inpatient or an observation patient for less than 8 hours, we would pay for only the admission service (CPT codes 99221 to 99223 or 99218 to 99220) on that day. The discharge service is not considered to be a separately billable service.

Inpatient or observation stay of 8 or more hours, but less than 24 hours - If a patient is admitted as a hospital inpatient or an observation patient for a period of 8 or more hours, but less than 24 hours, we would pay for both the admission and discharge services under CPT codes 99234 to 99236 with the following proposed physician work RVUs and documentation requirements:

Physician Work RVUs

To properly value both the admission and discharge work of these services, we are proposing to continue valuing the admission portion of the physician work as equivalent to CPT codes 99218 to

99220 (or CPT codes 99221 to 99223), but to reduce the discharge work RVUs from 1.28 to 0.67. This would make the discharge portion of the work equal to the work for CPT code 99213 (Office or other outpatient visits) instead of CPT code 99217 (or CPT code 99238). Thus, the proposed work RVUs would be as follows: CPT code 99234--1.95 RVUs; CPT code 99235--2.81 RVUs; CPT code 99236--3.66 RVUs. We would not pay CPT codes 99217, 99238, and 99239 for hospital inpatient or observation admissions between 8 and 24 hours in length.

Our reasoning for these proposed RVUs is that we believe that the physician work typically required for discharging an inpatient or observation admission patient after a period of at least 8 hours, but less than 24 hours, is less than that required for an admission of 24 hours or more. The typical work (for example, history, physical examination, and medical decision making) and the typical face to face time required to discharge such a patient is comparable to the requirements for CPT code 99213. Moreover, the typical time for CPT code 99238 is up to 30 minutes and the physician work is 1.28 RVUs, so a clear work anomaly would be created if we made the work value of discharging a patient with a stay of less than 24 hours identical to the work of discharging a patient with a length of stay of 24 hours or more.

Our proposal would avoid creating such a rank order anomaly and would place admission and discharge valuation in proper order. For example, for observation stays of less than 8 hours, we would pay only the admission portion and would not pay separately for the discharge because the extra work is minimal. For observation stays of more than 8 hours, but less than 24 hours, we would recognize the discharge component since there is significant extra work involved, but not as much as a discharge for a 24 hour or longer admission for which we would pay the full value of CPT code 99238. Our proposal would allow payment for CPT codes 99234 through 99236 only for stays of equal to or greater than 8 hours, but less than 24 hours.

In addition to the documentation guidelines for history, physical examination, and medical decision making described in CPT 2000 for CPT codes 99234 to 99236, we would require the following to be documented in the medical record:

- A stay involving 8 hours, but less than 24 hours.
- That the billing physician was present and personally performed the services.
- Admission and discharge notes written by the billing physician.

We believe this policy would harmonize current policy on hospital admissions and discharges and also accommodate the observation codes as they are described in CPT 2000. The policy

would not be tied to the "midnight" time frame of the hospital inpatient census.

If these proposals are adopted in the final rule, the work RVUs for CPT codes 99234 to 99236 would be considered interim for 2001.

G. Ocular Photodynamic Therapy and Other Ophthalmological Treatments

Ocular photodynamic therapy is a treatment recently approved by the Food and Drug Administration for age-related macular degeneration, the most common cause of blindness in the elderly. For CPT 2000, ocular photodynamic therapy was added to CPT code 67220, which was formerly limited to photocoagulation by laser.

We believe that ocular photodynamic therapy is significantly different from laser photocoagulation and, therefore, we are proposing to establish new HCPCS codes that specifically identify these procedures. A discussion of each of these codes follows:

Gxxx5 Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., by laser), one or more sessions

This code would be used in place of CPT code 67220. We would maintain the work and malpractice RVUs and the CPEP inputs

presently used for CPT code 67220 for payment of this new "G" code.

Gxxx6 Destruction of localized lesion of choroid (e.g., choroidal neovascularization); ocular photodynamic therapy (includes intravenous infusion)

We are proposing a value of 0.55 work RVUs for Gxxx6. This value is half the physician work value for CPT code 96570 (Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes), and it is identical to the physician work value for CPT code 96571 (Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes). We note that the total time of laser light application for ocular photodynamic therapy is 83 seconds, which is considerably shorter than the time of laser light application for CPT codes 96570 and 96571.

We are also proposing that the global period for Gxxx6 be "XXX." Because of the global designation, significant, separately identifiable evaluation and management (E/M) services may be billed on the same day as Gxxx6 with the use of the -25 modifier. Patients will, typically, have fluorescein angiography as well as an E/M service before ocular photodynamic therapy to determine whether they will benefit from the therapy and to

discuss the treatment. Any E/M services performed after the treatment may be billed separately.

For Gxxx6 we are proposing the following practice expense inputs for non-facility settings:

- *Clinical Staff Time*: Registered nurse/ophthalmology technician -- 40 minutes.
- *Supplies*: Ophthaine, mydriacil, myolfrin, gonisol, post myd spectacles, verteporfin and also infusion supplies including sterile and non-sterile gloves, butterfly needle, syringe, band aid, alcohol swab, staff gown, iv infusion set, and infusion pump cassette.
- *Equipment*: Laser, infusion pump, and exam lane.

For the malpractice component of Gxxx6, we are proposing 0.52 RVUs (the value assigned to CPT code 67220, Destruction of localized lesion of choroid). Although we are establishing procedure codes for ocular photodynamic therapy, coverage of the procedure is at the discretion of the local carrier.

In instances where both eyes are treated the same day, we are proposing the use of the following HCPCS add-on code:

Gxxx7 Destruction of localized lesion of choroid (for example, choroidal neovascularization); ocular photodynamic therapy (includes intravenous infusion)-other eye (List separately in addition to Gxxx6)

For this add-on code we are proposing a "ZZZ" global period, with .28 work RVUs (half of that proposed for Gxxx6) and .52 malpractice RVUs (identical to that proposed for Gxxx6). The practice expense inputs for services in the non-facility setting would be as follows:

• *Clinical Staff Time*: Registered nurse/ophthalmology technician -- 5 minutes.

• *Supplies*: Ophthaine, mydriacil, myolfrin, gonisol.

In addition, we have identified several other specific ophthalmological treatments that are not distinctly identified in CPT 2000. We are proposing to establish specific HCPCS codes for these procedures.

Gxxx8 Destruction of localized lesion of choroid (e.g., choroidal neovascularization); transpupillary thermotherapy, one or more sessions

Gxxx9 Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation, feeder vessel technique, one or more sessions

Gxx10 Destruction of macular drusen, photocoagulation, one or more sessions

We are not proposing RVUs for HCPCS codes Gxxx8 through Gxx10. These codes are being established for tracking purposes

only. These procedures are considered experimental in nature at this time and, therefore, are not covered under Medicare.

H. Electrical Bioimpedance

Electrical bioimpedance (EB), a noninvasive method of measuring cardiac input, is a covered procedure under Medicare, if medically necessary. Performance of this procedure is reported by the Level 2 HCPCS code M0302, and the procedure is currently carrier priced. We are proposing the following RVUs for this procedure:

1. Practice Expense

We are proposing the following direct inputs for determining practice expense RVUs. (We note, however, that a final determination of the practice expense RVUS will depend on how we value physician work.) The practice expense RVU in Addendum B reflects the value for the technical portion of the service. If the service is given physician work, a separate PC will be established with an additional practice expense RVU.

- *Clinical staff.* Registered nurse -- 15 minutes.
- *Supplies.* Four disposable sensors, patient gown, exam table paper, and pillowcase.
- *Equipment.* Cardiac output monitor and exam table.

2. Malpractice

We are proposing 0.02 RVUs for this procedure. This value is equivalent to the TC of an EKG, which is a similar procedure.

3. Physician Work

The uses for which this procedure are covered (for example, differentiating cardiogenic from pulmonary causes of acute dyspnea, the need for intravenous inotropic therapy, fluid management, and the uses indicated in section 50-54 of the Coverage Issues Manual, HCFA Pub. 6) require a clinical evaluation of the patient on the same day that EB is performed. The procedure reports measurements that can not be interpreted without other clinical information.

With respect to proposed RVUs for physician work, we have insufficient information to propose a work value. We are collecting information and invite comments on this subject as well as on the proposed inputs for practice expense and malpractice. In your comments, please be sure to compare your proposed value for the physician work component for this service to other similar services with established physician work values. Please also include the reason why you believe the physician work is similar. At this time, we have received comments proposing no physician work values, proposing physician work values similar to that for the interpretation of an EKG (CPT code 93010--0.17 work RVUs), proposing work values similar to total body plethysmography (CPT code 93720--0.17 work RVUs), and similar to

interpretation of cardiovascular stress test (CPT code 93018--0.30 work RVUs).

We also are proposing that the payment for this procedure be included in reporting critical care. Therefore, separate payment would not be made for this procedure when provided in conjunction with critical care services (CPT codes 99291 and 99292).

I. Global Period for Insertion, Removal, and Replacement of Pacemakers and Cardioverter Defibrillators

Currently, there is a 90-day global period in the physician fee schedule for all CPT codes involving the insertion, removal, and replacement of pacemakers or cardioverter defibrillators. During the global surgical period, no separate payment may be made for any E/M service furnished by the surgeon, unless the visit is: 1) unrelated to the diagnosis for which the surgical procedure was performed; 2) for treating the underlying condition; or 3) an added course of treatment that is not part of normal recovery from surgery.

In these situations, the surgeon must use CPT modifier -24 that attests that the E/M service provided, although performed during the postoperative period, was for a reason unrelated to the original procedure. Services submitted with a -24 modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-9-CM code that clearly

indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

Many patients receiving pacemakers or cardioverter defibrillators have clinically serious cardiac diseases (related to the reason for the procedure) that require significant postoperative care. In these cases, it is difficult to separate care during the postoperative period for the related cardiac problem(s) from the postoperative care for the pacemaker or cardioverter defibrillator procedure. As medical practice has changed, cardiologists predominantly perform pacemaker or cardioverter defibrillator procedures. Thus, the physician performing the pacemaker or cardioverter defibrillator procedure now is typically the same physician who is expected to furnish care for the patient's related cardiac disease. Therefore, a single physician is providing postoperative care for both the pacemaker or cardioverter defibrillator insertion and the related medical problem(s), but can be paid only for the insertion because of the global period policy.

We believe it is common for patients undergoing pacemaker and cardioverter defibrillator procedures to require significant care for related cardiac disease during the postoperative period. This care overlaps substantially with the care furnished for the pacemaker or cardioverter defibrillator procedure and may be coded with the same ICD-9-CM diagnosis code; therefore, using the

-24 modifier is inadequate to allow appropriate payment for the physician performing both postoperative care and care for the patient's other cardiac conditions.

We are proposing to change the global period for CPT codes 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33218, 33220, 33233, 33234, 33235, 33240, 33241, 33244, 33249, 33282, and 33284 from 90 days to 0 days. This would permit separate payment for any care furnished during the postoperative period by the physician who performed the pacemaker or cardioverter defibrillator procedure.

We are soliciting comments on whether it is appropriate to reduce the global period for these CPT codes. We are also proposing to ask the RUC to revise the RVUs for these CPT codes. If RUC recommendations are not received in time for our consideration for the CY 2001 physician fee schedule final rule, we propose to implement interim work RVUs, as listed below.

CPT Code	2000 Work RVUs	Proposed Work RVUs
33206	6.67	3.11
33207	8.04	3.30
33208	8.13	2.64
33212	5.52	3.32
33213	6.37	4.92
33214	7.75	4.27
33216	5.39	3.21
33217	5.75	3.57
33218	5.44	3.26

33220	5.52	2.90
33233	3.29	1.11
33234	7.82	5.64
33235	9.40	4.58
33240	7.50	5.13
33241	3.24	1.51
33244	13.76	9.85
33249	14.23	11.41
33282	4.17	2.83
33284	2.50	1.16

In calculating the proposed interim RVUs, we have subtracted the work RVUs of all postoperative visits after the day of surgery from the total work RVUs. We used our database to calculate the number of postoperative visits. Where our database did not contain the number of postoperative visits, we crosswalked a number from the most clinically similar procedure. We have included an example to illustrate the calculation.

Example:

For CPT code 33206, the 2000 work relative value is 6.67 units. The proposed work value is 3.11 (6.67 minus 3.56). The 3.56 units represents the work based on the pattern of E/M services in the global period.

E/M	**Frequency**	**Work**	**Total**
99213	1.5	.67	1.00
99231	2.0	.64	1.28

99238	1.0	1.28	1.28
Total E/M Work		**3.56**	

We would also adjust practice expense inputs for supplies, staff time, and equipment to account for the change in the global period. Because these would be 0-day global services only priced in the facility setting, there would be no direct CPEP inputs associated with them. The adjusted practice expense RVUs are reflected in Addendum B.

We welcome comments on our proposed calculation of interim RVUs and request that commenters recommending RVUs include the methodology employed so that we can appropriately evaluate the recommended RVUs. As an alternative to applying a 0-day global period as discussed above, we are interested in other suggestions that might address the issue of assuring appropriate payment for these services (for example, adjusting the global period to 10 days for these services). We invite public comment on such alternatives.

J. Antigen Supply

Section 410.68(b), Antigens: Scope and conditions, provides for beneficiaries to receive a supply of antigen for no more than 12 weeks at one time. A specialty society has indicated that this limitation is not reflective of current industry standards and guidelines (for example, duration of potency for allergy

extracts has changed since the policy was implemented.) Therefore, we are proposing to change this limitation from 12 weeks to 12 months and would revise the regulations to reflect this change. We are requesting comments on this proposal.

K. Low Intensity Ultrasound

In the November 1999 (64 FR 59419) final rule, we assigned RVUs to CPT code 20979, low intensity ultrasound stimulation to aid bone healing. Commenters expressed concern about the RVUs assigned to this service. Because of the concerns raised by commenters, and because CPT code 20979 is a noncovered service under Medicare, we are proposing to remove the RVUs that were assigned to this code at this time. We may reconsider this at a future date.

L. Implantation of Ventricular Assist Devices

In the April 11, 2000 correction notice (65 FR 19332) to the November 1999 final rule, we inadvertently published practice expense RVUs based on the work RVUs associated with a 90-day global period for CPT codes 33975 and 33976 (implantation of ventricular assist devices). However, in the same notice, the global periods and associated work RVUs for CPT codes 33975 and 33976 were revised to reflect an "XXX" (the global concept does not apply). In calculating the practice expense RVUs, we reflected changes made in CPEP data that result from changes in

the global period. However, the practice expense RVUs are also a function, in part, of the physician work RVUs. In calculating the revised practice expense RVUs, we did not use the work RVUs that reflected the global period change. Effective January 1, 2001, we would revise the practice expense RVUs associated with the these CPT codes to reflect the revision in the global periods and work RVUs.

III. Other Issues

A. Incomplete Medical Direction

Under current policy, medical supervision by an anesthesiologist occurs if the anesthesiologist is involved in furnishing more than four concurrent procedures or is performing other services while directing fewer than four concurrent procedures. Payment is based on three base units plus one unit for induction if the physician is present at induction.

Under current policy, medical direction by an anesthesiologist occurs if the anesthesiologist is involved in two to four concurrent anesthesia procedures or a single anesthesia procedure with a qualified anesthetist. For each anesthesia procedure, the anesthesiologist must--

- Perform a pre-anesthesia examination and evaluation;
- Prescribe the anesthesia plan;

• Personally participate in the most demanding procedures of the anesthesia plan, including emergence and induction;

• Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

• Monitor the course of anesthesia administration at frequent intervals;

• Remain physically present and available for immediate diagnosis and treatment of emergencies; and

• Provide indicated post anesthesia care.

We currently do not have a national policy that instructs the carriers how to pay for a service when the anesthesiologist does not fulfill all the medical direction requirements. One option carriers may use is to instruct the anesthesiologist to report this service as a reduced or unusual service and determine appropriate payment. We are considering clarifying this policy and making other revisions to the medical supervision payment policy. We are considering the following:

1. To specify that the physician furnishing medical supervision must perform, at a minimum, the preoperative evaluation, participate in induction, remain available for consultation, and provide a minimum level of monitoring.

2. To establish payment for medical supervision at 40 percent of the payment amount for the service performed by the physician alone.

3. To apply the proposed medical supervision payment amounts to incompletely medically-directed cases.

4. To limit the number of concurrent cases the physician can supervise to five concurrent cases.

Payment for medical supervision is payment for the physician service. In addition, the certified registered nurse anesthetist (CRNA) service furnished under medical supervision is paid at 50 percent of the amount that would have been paid if the service had been performed by the physician alone.

We invite comments from the public, but in particular, the physicians and practitioners most affected by this policy. We are not proposing a change at this time, but will consider the comments we receive should we develop a future proposal.

B. Payment for Pulse Oximetry Services

In the November 1999 final rule (64 FR 59413), we indicated that we would adopt our proposal to bundle payment for certain diagnostic codes, including pulse oximetry CPT codes 94760 and 94761, into the payment for other services. We believe that continuing to pay separately for these codes duplicates amounts included in both facility payments and practice expense RVUs. However, we did not address how we would treat situations when these services are performed without any other billable service and, thus, are not reflected in facility payments or other practice expense RVUs. We will continue to pay separately for

these services (CPT codes 94760 and 94761) when they are medically necessary and there are no other services payable under the physician fee schedule billed on the same date by the same supplier.

C. Outpatient Therapy Supervision

In the November 1998 final rule (63 FR 58868), we stated that we were maintaining our current requirement that therapy assistants of therapists in private practice (formerly known as therapists in independent practice (PTIP)) must be personally supervised by the therapist and be employed directly by the therapist; employed by the partnership or group to which the therapist belongs; or employed by the same practice. Personal supervision requires that the therapist be in the same room during the performance of the service. Levels of supervision are defined at §410.32 (Diagnostic X-ray tests, diagnostic laboratory, and other diagnostic tests: Conditions.)

The November 1998 final rule did not change pre-existing regulations at §410.60(c)(2) (Supervision of physical therapy services) for therapy assistants in a private practice setting. In that final rule, we codified the statutory requirements for coverage of outpatient occupational therapy services by establishing §410.59 (Outpatient occupational therapy services: Conditions). Section 410.59 parallels the requirements in §410.60 for outpatient physical therapy, as revised in the

November 1998 final rule. We also made conforming changes in §410.61 (Plan of treatment requirements for outpatient rehabilitation services) to include occupational therapy.

The personal supervision requirements for therapy assistants and aides in a private practice setting are long-standing. The outpatient physical therapy benefit, enacted in 1972, applied to PTIP (that is, individual therapists in independent practice in their own offices). Services performed by employees of a PTIP were covered if furnished under the direct personal supervision of the PTIP. This requirement was necessary to assure beneficiary health and safety and quality of care.

In 1981, in response to the conference committee report (H.R. 96-1479) accompanying the Omnibus Reconciliation Act of 1980 (Public Law 96-499), we revised our Medicare Carriers Manual instructions (see section 2215F, HCFA Pub. 6). These revised instructions stated that the services of employees of a PTIP who are not qualified physical therapists must be furnished under the direct personal supervision of a supervising therapist who must be the employer or on the employer's staff. Therefore, a licensed physical therapist had to directly and personally supervise the services of assistants and aides. Thus, even before the November 1998 final rule, the regulations and manuals clearly stated that the PTIP must directly and personally supervise all services for which he or she bills.

As noted above, pre-existing supervision requirements for therapy assistants in a private practice setting were not affected by the November 1998 final rule. However, we received comments from the therapy industry and other interested parties who erroneously believed that we had either misinterpreted the supervision requirement or had established a new requirement for therapy assistants in the private practice setting.

These comments and the confusion possibly resulted from the one revision in supervision requirements made in the final rule. This revision related **not** to therapy assistants, but to qualified **therapists** in a private practice setting. As referenced in the November 1998 final rule (63 FR 58868), the Congress was concerned about the requirement for therapists in independent practice to directly supervise all services performed by their employees, even if those employees were fully-licensed therapists. The therapist in independent practice had to be on the premises whenever services were furnished to Medicare beneficiaries, including services furnished by a licensed therapist. Therefore, a therapist in independent practice could not have more than one office open at the same time because he or she could not be on both premises at once. Congressional statements in both the House and Senate committee reports associated with our fiscal year 1997 appropriations process

addressed this issue. The House committee report urged us to modify the regulations so that certified therapists need not be on the premises to supervise other licensed therapists. We were also urged by the Senate to review this concern and recommend changes in our regulations or instructions. To address this concern expressed in both the 1997 House and Senate Appropriations Committee reports, we revised the regulations at §410.59(c)(2) and §410.60(c)(2).

Accordingly, effective January 1, 1999, as specified in the November 1998 final rule, the revised regulations permit legally authorized (see §410.59(c)(1)(i) and §410.60(c)(1)(i)) therapists who own the practice to be off the premises when other legally authorized therapists are present to furnish supervision for therapy assistants. These regulations also restated which practitioners are qualified as therapists under section 1861(p) of the Act. In accordance with the November 1998 final rule, the term "independent" was removed from the description of a therapist in independent practice. In its place, the term "private" was added. The benefit is now described in terms of an individual physical therapist or occupational therapist in private practice.

This change did not affect the required degree of supervision for physical therapist assistants. Assistants still must be personally supervised by the therapist in private

practice and employed directly by the therapist, by the partnership, or group to which the therapist belongs.

D. Outpatient Therapy Caps

Section 221 of the BBRA placed a 2-year moratorium on Medicare Part B outpatient therapy caps (the $1500 cap on outpatient physical therapy services including speech language-pathology services and the $1500 cap on outpatient occupational therapy services in all nonhospital settings). The two $1500 caps were implemented in 1999 as required by the BBA.

The BBRA also requires us to submit to the Congress a report by January 1, 2001 that includes recommendations on -- (1) the establishment of a mechanism for assuring appropriate utilization of outpatient therapy services; (2) the establishment of an alternative payment policy for these services based on classifications of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and other criteria, in place of uniform dollar limitations; and (3) how to do this in a budget-neutral manner.

We are gathering information on alternatives or options that we can use to achieve these objectives. We have received the following informal recommendations for legislation:

- Institute a cap per diagnosis rather than per year.

• Establish payment based on patient groupings by primary diagnosis and average number of treatments, with options for variants.

• Base payment on an episode of occurrence of illness or injury, with a cap amount adjusted to address geographic differences in the cost of furnishing services.

• Develop a sustainable growth rate (SGR) for outpatient therapy services to control growth in the volume of services.

The outpatient therapy cap was also a topic of discussion at the PPAC meeting in December 1999. As a result of these discussions, the PPAC recommended continuation of the current moratorium with focused medical review, indicating that such a review could lead to the desired budget-neutral outcome.

We would like comments from the public on additional alternatives that we could consider in developing a payment policy for outpatient therapy services. We will consider this information as we prepare our report to the Congress on outpatient therapy services.

IV. Five-Year Refinement of Relative Value Units

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs for services in the physician fee schedule no less often than every 5 years. The first 5-year review was undertaken as part of the final rule published December 1994 (59 FR 63140), with the resulting changes effective for services furnished

beginning January 1, 1997. In the final rule published November 1999 (64 FR 59427), we included a discussion of the first 5-year refinement and outlined our plans for the second 5-year refinement of work RVUs. We also solicited comments on potentially misvalued work RVUs as well as data sources and methodologies to assist us in identifying misvalued services. We received comments from approximately 30 specialty groups, organizations, and individuals. While some of the comments were on the proposed process, comments also included requests for evaluating over 900 codes.

As we had discussed in the November 1999 final rule, in addition to performing internal review and analysis, we will be sharing these comments with the RUC, which currently makes recommendations to us on the assignment of RVUs to new and revised CPT codes. The RUC's perspective will be helpful because of its experience in recommending RVUs for the codes that have been added to the CPT, or revised by the CPT panel, since we implemented the physician fee schedule in 1992. We emphasize, however, as we reiterated for the first 5-year review, we have the responsibility for analyzing the comments concerning the 5-year review and deciding whether to revise RVUs. We are not delegating this responsibility to the RUC or any other organization.

Current initiatives underway (see discussion that follows on physician time) will assist us in our identification of misvalued codes. However, we will not be able to identify those codes that we believe have misvalued work RVUs before late in the year 2000 or early in the year 2001. We propose to perform the 5-year review in two phases. The first phase will take place in CY 2000 with consideration of public comments. The second phase will occur in CY 2001 when we use the contracted research to identify misvalued codes. We will work with the RUC and the medical community to minimize work duplication. For example, we will ask the RUC to defer action in CY 2000 on those codes that were identified by public comments and that our research later indicates might be misvalued. Furthermore, to focus on each phase of the review and prevent duplicative work, we propose to concentrate on intraspecialty issues and anomalies in CY 2000 and consider cross specialty misvaluations and issues in CY 2001. This is because we believe that validation of time across a wide range of services will allow direct comparison of pre-, intra-, and postservice work RVUs across specialties with the potential to identify a large number of misvalued codes. Again, we will work closely with the medical community to analyze and interpret the data as well as to organize the review in an efficient manner.

Physician Time Data

We currently have initiatives underway to validate the physician time data and identify potentially misvalued codes to be considered during the 5-year review. A discussion of these activities follows.

Under a contract with HCFA, Health Economics Research (HER) is reviewing secondary data sources to validate time estimates for physicians' services. Physician time estimates are a factor used in the calculation of the practice expense RVUs and one of the primary determinates of physician work. These secondary data sources are as follows:

- The National Ambulatory Medical Care Survey (NAMCS).
- D.J. Sullivan Associates Hospital Data.
- MGMA Practice Cost Survey Data.

The NAMCS is a survey conducted by the Center for Disease Control that collects self-reported information on over 20,000 office visits annually including physician face-to-face time (called the duration of the visit). Various comparative analyses, both at the physician specialty level and for all physicians, can be made between projected E/M codes in the NAMCS data and with the actual E/M codes reported in the Medicare Part B National Claims History. (E/M codes are not captured in the NAMCS data. However, a method is used to map the time of the physician visit to an appropriate E/M code. This represents the

"projected" E/M code.) The analysis was performed on the 1997 NAMCS.

The D.J. Sullivan database groups approximately 495,000 inpatient and outpatient records into 177 small clinically similar classes. The database captures information from the hospital record such as the procedure, time the patient enters the operating room, time of incision, time of wound closure, and time the patient exits the operating room. Data are presented for all hospitals and for all hospitals by categories: community hospitals, teaching hospitals, and university-based hospitals.

HER is analyzing a sample of the D.J. Sullivan database to determine whether it can be used for validating skin-to-skin time for selected surgical procedures. The selected procedures are high volume procedures or procedures on the RUC multispecialty list.

The MGMA Physician Profiling Database contains information at the physician practice level on the number of services by CPT code, physician specialty, and clinical work week. The database contains information on almost 4,000 physicians, primarily from Florida, Minnesota, New York, and Washington. Analysis will focus on comparing expected clinical times based on current time estimates attributable to CPT codes to total practice hours worked.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and we will respond to the major comments in the final rule.

VII. Regulatory Impact Analysis

We have examined the impacts of this proposed rule as required by Executive Order of 1993 (EO) 12866, the Unfunded Mandates Reform Act of 1995 (EO) 12875 (UMRA) (Public Law 104-4), the Regulatory Flexibility Act of 1980 (RFA) (Public Law 96-354) and the Federalism Executive Order of 1999 (EO) 13132.

EO 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules

with economically significant effects ($100 million or more annually). While the changes in the Medicare physician fee schedule are for the most part, budget neutral, they do involve redistribution of Medicare spending among procedures and physician specialties and geographic areas. However, the redistributive effect of this rule on any particular specialty or geographic area is, in our estimate, unlikely to exceed $100 million. The effect of the practice expense changes are estimated to increase payments to one specialty by about $90 million and decrease payments to another specialty by approximately $45 million. All other physician specialties will be affected by less than these amounts. The GPCI changes are expected to increase payments by less than $10 million in one locality and decrease payments by about $20 million in another locality. The effect on all other payment localities are likely to be less than these amounts. Since we estimate that these changes are unlikely to redistribute more than $100 million in Medicare allowed charges, we are not considering this proposed rule to be a major rule. However, we will reconsider this decision for the final rule if our estimates based on new data exceed $100 million.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in expenditure in any one

year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more. We have determined that this proposed rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below the above stated threshold as well.

The RFA requires that we analyze regulatory options for small businesses and other small entities. We prepare a Regulatory Flexibility Analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification of why action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives and lessen significant adverse economic impact on the small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

For purposes of the RFA, all physicians are considered to be small entities. There are about 700,000 physicians and other practitioners who receive Medicare payment under the physician fee schedule. We have prepared the following analysis, which, together with the rest of this preamble, meets all four assessment requirements. It explains the rationale for and purpose of the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we considered to minimize the burden on small entities.

A. Resource-Based Practice Expense Relative Value Units

Revisions in resource-based practice expense RVUs for physicians' services are calculated to be budget neutral, that is, the total practice expense RVUs for calendar year 2001 are calculated to be the same as the total practice expense RVUs that we estimate would have occurred without the changes proposed in this regulation. This also means that increases in practice expense RVUs for some services will necessarily be offset by corresponding decreases in values for other services.

Table 1 shows the impact on total allowed charges by specialty of this proposed rule's practice expense changes. There are six changes that we made that have on effect on payment for practice expenses. We show the impact of each individual provision and the combined impact on the practice expense RVUs.

Table 1 -- Impact of Specific Practice Expense Changes on Total Allowed Charges by Specialty

Specialty	Allowed Charges	Clinical Staff	Overhead Equipment	"Standby Equipment	Midlevel Practitioners	New SMS Data	Other	Total
ANESTHESIOLOGY	1.5	0%	-0%	0%	-1%	0%	-0%	-1%
CARDIAC SURGERY	0.3	-0	0	-0	-1	-2	0	-3
CARDIOLOGY	3.9	-0	-0	0	0	-0	-0	-0
CLINICS	1.5	-0	0	-0	0	0	-0	0
DERMATOLOGY	1.3	-0	1	-1	0	-0	0	-0
EMERGENCY MEDICINE	0.9	0	-0	0	0	-0	0	0
FAMILY PRACTICE	3.2	-0	0	-0	0	-0	-0	-0
GASTROENTEROLOGY	1.1	2	-0	-0	0	0	0	2
GENERAL PRACTICE	1.0	-0	0	-0	0	0	-0	0
GENERAL SURGERY	1.9	0	0	-0	-0	-0	-0	-1
HEMATOLOGY ONCOLOGY	0.6	-0	-0	-0	0	-0	-0	-1
INTERNAL MEDICINE	6.7	-0	-0	-0	0	-0	-0	-0
NEPHROLOGY	0.9	0	0	0	0	1	0	2
NEUROLOGY	0.8	-0	-1	-0	0	0	0	-0
NEUROSURGERY	0.3	-0	-0	-0	-0	-1	0	-1
OBSTETRICS/GYNECOLOGY	0.4	-0	-1	-0	0	-0	0	-1
OPHTHALMOLOGY	3.7	-0	0	0	0	-2	0	-1
ORTHOPEDIC SURGERY	2.2	-0	0	-0	-0	0	-0	-0
OTHER PHYSICIAN	1.3	-0	-0	-0	0	1	-0	1
OTOLARYNGOLOGY	0.6	-0	-0	-0	0	-1	-0	-1
PATHOLOGY	0.6	0	-1	1	0	-2	1	-1
PLASTIC SURGERY	0.2	-0	0	-0	0	0	-0	0
PSYCHIATRY	1.1	0	0	-0	0	-1	-0	-1
PULMONARY	1.0	0	-0	-0	0	-0	-0	-0
RADIATION ONCOLOGY	0.6	0	-0	0	0	0	0	1
RADIOLOGY	2.9	0	-0	0	0	3	-0	3
RHEUMATOLOGY	0.3	-0	-0	-0	0	0	-0	-1
THORACIC SURGERY	0.5	-0	0	-0	-1	-1	-0	-2
UROLOGY	1.3	-0	0	-0	0	-0	-0	-0
VASCULAR SURGERY	0.3	-0	-0	-0	-0	-0	-0	-1
OTHERS:								
CHIROPRACTOR	0.4	0	-0	-0	1	1	-0	1
NONPHYSICIAN PRACTITIONER	0.9	-0	0	0	0	3	-0	4
OPTOMETRIST	0.5	-0	0	0	0	-2	0	-2
PODIATRY	1.1	-0	0	-0	0	-0	0	0
SUPPLIERS	0.5	0	-3	2	0	-1	0	-1
Note: Total may not add due to rounding.								

The column labeled "Clinical Staff" refers to the proposal discussed earlier with respect to clinical staff times and 0-day

global surgical services. As we indicated, clinical staff times for pre- and postsurgical services provided in the office were reinstated to the estimates of practice expense inputs for individual procedures. This change has nearly a 2.0 percent increase in payments for gastroenterology and small positive or negative impacts for all other specialties. The negative impacts on some specialties offset the positive impact for other specialties.

The column labeled "Overhead Equipment" refers to the provision described earlier to remove the distinction between procedure specific and overhead equipment. As we indicated, this change is largely designed to simplify the refinement process and remove a distinction that was more relevant under the "bottom-up" rather than the "top-down" methodology for determining the practice expense RVUs. This proposal has some small impacts on a few specialties.

The column labeled "Standby Equipment" refers to our proposal to remove certain types of equipment from equipment inputs that are used to value individual procedure codes. These types of equipment are not typically used with any individual service, but are on "standby" or used for multiple services at the same time. This proposal also has some small impact on payments to a few specialties.

The column labeled "Midlevel Practitioners" refers to the provision we described earlier to remove utilization data associated with the provision of services by midlevel practitioners that are paid a percentage of the physician fee schedule amount. This change to the model would mean that we would no longer create separate practice expense pools for midlevel practitioners. It would also mean that specialty-specific practice expense RVUs for midlevel practitioners determined after the scaling factor adjustments are made would no longer be used in the weight averaging step.

The greater the extent that allowed services for midlevel practitioners represent a higher proportion of the total number of allowed services for a given code, the more likely this change will have an impact on the practice expense RVU for the service. In some cases, this change would mean that we are no longer weight averaging specialty-specific practice expense RVUs that are higher in value than the RVUs determined for the remaining physician specialties. This would cause the practice expense value for the service to decline in value from what would result from including higher specialty-specific practice expense RVUs for the midlevel practitioner. In general, the impact of this provision would be small for most specialties. The impact on specialty level payments are more likely for specialties that

frequently perform services in conjunction with midlevel practitioners.

The column labeled "New SMS Data" refers to our proposal to recalculate the practice expense per hour data based on data from the 1995 through 1998 SMS. (We refer to the SMS based on its publication year. The practice expense data is actually from surveys performed the year prior to publication. For example, the 1998 SMS includes 1997 cost data.) As indicated in the table, this change would have an impact on specialty level payments. These changes in payment would be in the same direction as relative changes in the practice expense per hour. That is, an increase in practice expense per hour for a specialty relative to other specialties would result in increased payments for that specialty. For cardiac and thoracic surgery, there is an additional factor influencing the impact. As we indicated in the November 1999 final rule (64 FR 59391), we weight averaged 1998 SMS data from an oversample for cardiac and thoracic surgery with data from the 1996 and 1997 SMS. At that time, we did not use data from the 1995 SMS in determining the practice expense per hour. Since we are using 1995 through 1998 SMS data for all other physician specialties, we recalculated the practice expense per hour for cardiac and thoracic surgery using data from the 1995 through 1998 SMS. In addition, we are continuing to use 1998 SMS data from the oversample in this calculation.

The total impact column shows the product of each individual provision for the years 2001 and 2002 relative to continuing with our current policy. The figures may not add due to rounding. Table 2 shows the total impact over the 2001 and 2002 period of these changes and the 2001 impact. The difference between the two columns reflects the effect of the transition to fully implemented practice expense RVUs. That is, the impact in the 2001 column will reflect 75 percent of the impact on the fully implemented RVUs. These impacts are in addition to the impacts announced in previous rules related to the adoption of resource-based practice relative value units.

Table 2 -- Impact of Practice Expense Changes Transition and 2001-2002 Impact

Specialty	Allowed Charges	Year 2001 Impact	2001-2002 Impact
ANESTHESIOLOGY	1.5	-1%	-1%
CARDIAC SURGERY	0.3	-2	-3
CARDIOLOGY	3.9	-0	-0
CLINICS	1.5	0	0
DERMATOLOGY	1.3	-0	-0
EMERGENCY MEDICINE	0.8	0	0
FAMILY PRACTICE	3.2	-0	-0
GASTROENTEROLOGY	1.1	2	2
GENERAL PRACTICE	1.0	0	0
GENERAL SURGERY	1.9	-0	-1
HEMATOLOGY ONCOLOGY	0.6	-0	-1
INTERNAL MEDICINE	6.7	-0	-0
NEPHROLOGY	0.9	1	2
NEUROLOGY	0.8	-0	-0
NEUROSURGERY	0.3	-1	-1
OBSTETRICS/GYNECOLOGY	0.4	-1	-1
OPHTHALMOLOGY	3.8	-1	-1
ORTHOPEDIC SURGERY	2.2	-0	-0
OTHER PHYSICIAN	1.3	0	1
OTOLARYNGOLOGY	0.6	-1	-1
PATHOLOGY	0.6	-0	-1
PLASTIC SURGERY	0.2	0	0
PSYCHIATRY	1.1	-0	-1
PULMONARY	1.0	-0	-0
RADIATION ONCOLOGY	0.6	1	1
RADIOLOGY	2.9	2	3
RHEUMATOLOGY	0.3	-1	-1
THORACIC SURGERY	0.5	-2	-2
UROLOGY	1.3	-0	-0
VASCULAR SURGERY	0.3	-1	-1
OTHERS:			
CHIROPRACTOR	0.4	1	1
NONPHYSICIAN PRACTITIONER	0.9	3	4
OPTOMETRIST	0.5	-1	-2
PODIATRY	1.1	0	0
SUPPLIERS	0.5	-1	-1

Table 3 shows the impact on payments for selected high volume procedures of all of the practice expense changes

previously discussed. This table isolates the impact of the practice expense changes only on payments. It does not show what actual payments for these procedures will be in 2001 because the payment calculations do not include the effect of the transition or the impact of the physician fee schedule update which is unknown at this time.

Table 3 -- Total Payment for Selected Procedures

Code	Mod	Description	Old Non-facility	New Non-facility	Percent Change	Old Facility	New Facility	Percent Change
11721		Debride nail, 6 or more	39.542796	39.908933	0.009	28.924823	28.924823	0
17000		Destroy benign/premal lesion	60.046468	58.948057	-1.8293	32.586193	32.586193	0
27130		Total hip replacement	NA	NA	NA	1448.0718	1435.9893	-0.834
27236		Treat thigh fracture	NA	NA	NA	1082.6671	1079.3719	-0.304
27244		Treat thigh fracture	NA	NA	NA	1098.411	1097.3126	-0.1
27447		Total knee replacement	NA	NA	NA	1518.3701	1505.5553	-0.844
33533		CABG, arterial, single	NA	NA	NA	1853.7516	1803.957	-2.686
35301		Rechanneling of artery	NA	NA	NA	1126.2374	1112.3242	-1.235
43239		Upper GI endoscopy, biopsy	250.071571	288.149819	15.2269	142.06116	152.31299	7.2165
45385		Lesion removal colonoscopy	465.726264	482.934703	3.69497	278.63026	291.44505	4.5992
66821		After cataract laser surgery	203.938309	208.69809	2.33393	177.94258	185.63146	4.321
66984		Remove cataract/insert lens	NA	NA	NA	665.27093	665.27093	0
67210		Treatment of retinal lesion	603.027639	602.661502	-0.061	551.03619	550.67005	-0.07
71010	26	Chest x-ray	8.787288	9.153425	4.16667	8.787288	9.153425	4.1667
71020		Chest x-ray	34.416878	35.149152	2.12766	NA	NA	NA
71020	26	Chest x-ray	10.617973	11.350247	6.89655	10.617973	11.350247	6.8966
77430		Weekly radiation therapy	189.292829	190.757377	0.77369	189.29283	190.75738	0.7737
78465		Heart image (3d), multiple	528.335691	533.461609	0.9702	NA	NA	NA
88305		Tissue exam by pathologist	82.014688	87.140606	6.25	NA	NA	NA
88305	26	Tissue exam by pathologist	41.007344	40.641207	-0.8929	41.007344	40.641207	-0.893
90801		Psy dx interview	146.088663	144.990252	-0.7519	138.76592	138.39979	-0.264
90806		Psytx, off, 45-50 min	98.124716	97.392442	-0.7463	94.097209	93.731072	-0.389
90807		Psytx, off, 45-50 min w/e&m	103.982908	103.250634	-0.7042	99.589264	99.223127	-0.368
90862		Medication management	51.625317	50.893043	-1.4184	47.231673	46.865536	-0.775
90921		ESRD related services, month	259.95727	260.689544	0.28169	259.95727	260.68954	0.2817
90935		Hemodialysis, one evaluation	NA	NA	NA	62.24329	74.325811	19.412
92004		Eye exam, new patient	123.022032	116.797703	-5.0595	87.140606	86.774469	-0.42
92012		Eye exam established pat	63.707838	64.440112	1.14943	36.6137	36.247563	-1
92014		Eye exam & treatment	90.435839	91.53425	1.21457	58.948057	58.58192	-0.621
92980		Insert intracoronary stent	NA	NA	NA	809.52891	809.89504	0.045
92982		Coronary artery dilation	NA	NA	NA	608.15356	608.88583	0.1204
93000		Electrocardiogram, complete	26.361864	26.361864	0	NA	NA	NA
93010		Electrocardiogram report	8.787288	9.153425	4.16667	8.787288	9.153425	4.1667
93015		Cardiovascular stress test	105.081319	105.447456	0.34843	NA	NA	NA
93307		Echo exam of heart	199.910802	200.643076	0.3663	NA	NA	NA
93307	26	Echo exam of heart	50.160769	50.160769	0	50.160769	50.160769	0
93510	26	Left heart catheterization	232.130858	232.130858	0	232.13086	232.13086	0
98941		Chiropractic manipulation	34.783015	35.515289	2.10526	30.389371	30.755508	1.2048
99202		Office/outpatient visit, new	72.495126	69.932167	-3.5354	45.400988	45.400988	0
99203		Office/outpatient visit, new	101.786086	98.490853	-3.2374	68.833756	68.833756	0
99204		Office/outpatient visit, new	144.257978	139.13206	-3.5533	101.78609	102.15222	0.3597
99205		Office/outpatient visit, new	177.942582	170.619842	-4.1152	134.37228	134.73842	0.2725
99211		Office/outpatient visit, est	25.62959	26.728001	4.28571	9.153425	9.153425	0
99212		Office/outpatient visit, est	38.810522	39.176659	0.9434	23.066631	23.066631	0
99213		Office/outpatient visit, est	51.625317	51.991454	0.70922	33.684604	34.050741	1.087
99214		Office/outpatient visit, est	80.55014	76.88877	-4.5455	55.652824	56.018961	0.6579

Code	Mod	Description	Old Non-facility	New Non-facility	Percent Change	Old Facility	New Facility	Percent Change
99215		Office/outpatient visit, est	114.967018	112.037922	-2.5478	89.703565	89.703565	0
99221		Initial hospital care	NA	NA	NA	65.172386	65.538523	0.5618
99222		Initial hospital care	NA	NA	NA	108.01042	108.37655	0.339
99223		Initial hospital care	NA	NA	NA	149.3839	149.75003	0.2451
99231		Subsequent hospital care	NA	NA	NA	32.586193	32.586193	0
99232		Subsequent hospital care	NA	NA	NA	53.456002	53.456002	0
99233		Subsequent hospital care	NA	NA	NA	75.790359	76.156496	0.4831
99236		Observ/hosp same date	NA	NA	NA	212.35946	212.7256	0.1724
99238		Hospital discharge day	NA	NA	NA	64.073975	64.073975	0
99239		Hospital discharge day	NA	NA	NA	87.140606	87.506743	0.4202
99241		Office consultation	61.877153	58.58192	-5.3254	33.684604	34.050741	1.087
99242		Office consultation	101.419949	96.660168	-4.6931	67.003071	67.369208	0.5464
99243		Office consultation	128.14795	121.191347	-5.4286	89.337428	89.703565	0.4098
99244		Office consultation	175.74576	169.155294	-3.75	131.44318	132.17546	0.5571
99245		Office consultation	221.879022	216.386967	-2.4752	175.37962	176.47803	0.6263
99251		Initial inpatient consult	NA	NA	NA	36.979837	36.979837	0
99252		Initial inpatient consult	NA	NA	NA	71.396715	71.396715	0
99253		Initial inpatient consult	NA	NA	NA	97.026305	97.026305	0
99254		Initial inpatient consult	NA	NA	NA	138.03365	138.39979	0.2653
99255		Initial inpatient consult	NA	NA	NA	188.92669	189.65897	0.3876
99261		Follow-up inpatient consult	NA	NA	NA	23.432768	23.432768	0
99262		Follow-up inpatient consult	NA	NA	NA	45.400988	45.400988	0
99263		Follow-up inpatient consult	NA	NA	NA	66.270797	66.270797	0
99282		Emergency dept visit	NA	NA	NA	26.361864	26.361864	0
99283		Emergency dept visit	NA	NA	NA	58.215783	58.215783	0
99284		Emergency dept visit	NA	NA	NA	90.801976	91.168113	0.4032
99285		Emergency dept visit	NA	NA	NA	140.96275	141.32888	0.2597
99291		Critical care, first hour	185.631459	185.997596	0.19724	177.21031	177.94258	0.4132
99292		Critical care, addl 30 min	94.829483	94.829483	0	87.87288	88.239017	0.4167
99301		Nursing facility care	NA	NA	NA	59.680331	59.680331	0
99302		Nursing facility care	NA	NA	NA	79.817866	80.184003	0.4587
99303		Nursing facility care	NA	NA	NA	99.589264	99.955401	0.3676
99311		Nursing fac care, subseq	NA	NA	NA	30.023234	30.023234	0
99312		Nursing fac care, subseq	NA	NA	NA	49.428495	49.428495	0
99313		Nursing fac care, subseq	NA	NA	NA	70.298304	70.664441	0.5208
99348		Home visit, est patient	72.128989	71.762852	-0.5076	66.270797	66.270797	0
99350		Home visit, est patient	162.564828	162.198691	-0.2252	153.04527	153.4114	0.2392

B. Geographic Practice Cost Index Changes

Section 1848(e)(1)(A) of the Act requires that payments under the Medicare physician fee schedule vary among payment areas only to the extent that area costs vary as reflected by the area GPCIs. The GPCIs measure area cost differences in the three

components of the physician fee schedule: physician work, practice expenses (employee wages, rent, medical supplies, and equipment), and malpractice insurance. Section 1848(e)(1)(C) of the Act requires that the GPCIs be reviewed and, if necessary, revised at least every 3 years. The first GPCI revision was implemented in 1995. The second revision was implemented in 1998, and the next revision will be implemented in 2001. Section 1848(e)(1)(C) of the Act also requires that the GPCI revisions be phased in equally over a 2-year period if more than one year has elapsed since the last adjustment.

An estimate of the overall effects of proposed GPCI changes on fee schedule area payments can be demonstrated by a comparison of area geographic adjustment factors (GAFs). The GAFs are a weighted composite of each area's work, practice expense, and malpractice expense GPCIs using the national GPCI cost share weights. While not actually used in computing the fee schedule payment for a specific service, the GAFs are useful in comparing overall area costs and payments. The actual effect on payment for any actual service will deviate from the GAF to the extent that the service's proportions of work, practice expense, and malpractice expense RVUs differ from those of the GAF. Addendum H shows the estimated effects of the proposed GPCIs on area GAFs in descending order.

Only 14 of the 89 fee schedule areas would change by at least 2 percent. Only 16 areas would change by from 1 to 1.9 percent. The remaining 59 areas are estimated to experience payment changes of less than 1 percent under the proposed changes. These are very minor changes that would be expected in that we are revising only the rent indices, comprising 11.6 percent of the total GPCI, and the malpractice expense indices, comprising 3.2 percent of the GPCI. Thus, only about 15 percent of the GPCI would be subject to change. The effects in the transition year 2001, would only be one-half of these amounts as the proposed revised GPCIs would be phased in over a 2-year period as required by law.

C. Resource-Based Malpractice Relative Value Units

As indicated earlier, we are currently examining the more recent malpractice data. The malpractice RVUs in the fall final rule will reflect the newer data and the refinements made as a result of comments made on last year’s rules.

While we anticipate there would be little impact, this would be fully discussed in the final rule.

D. Critical Care Relative Value Units

As we explained earlier in the preamble in the November 1999 final rule, we established interim work RVUs for 2000 for CPT codes 99291 and 99292 (critical care services). These RVUs were

decreased due to concerns about changes in the CPT definition for these services. In this proposed rule, based on changes the Panel is making to the definition for critical care for CY 2001, we are proposing to increase the work RVUs for critical care services and value the physician work at 4.0 RVUs for CPT code 99291 and 2.0 RVUs for CPT code 99292. Any impact of this proposal would be incorporated in the physician fee budget neutrality calculation.

E. Care Plan Oversight

We are proposing to establish two new HCPCS codes for care plan oversight that are consistent with our coverage criteria. We would also establish two new HCPCS codes to describe the services involved in physician certification or recertification and development of a plan of care for a patient for whom the physician has prescribed Medicare-covered home health services.

We are assuming there would be no additional cost or savings as a result of the two new HCPCS codes for care plan oversight. We are merely instituting these codes for consistency with our coverage criteria, and they would be used in place of the CPT codes when these services are provided.

For the new HCPCS codes for physician certification or recertification and development of a plan of care, the payment for these services is currently included in the payment for a variety of services such as E/M that are provided independently

to patients as part of a global surgical service. Under this proposal, we would instead pay separately. Since we are proposing to pay separately for a service that is currently included in our payment for other services, this proposal would increase Medicare expenditures for physicians' services without an adjustment to the physician fee schedule CF. For this reason, we are proposing to adjust the physician fee schedule CF to ensure that Medicare payments for physicians' services do not increase as a result of this proposal.

F. Observation Care Codes

Our proposal is budget-neutral. We believe physicians have not been billing for the discharge component of a hospital or observation stay of less than 24 hours so those physicians would be seeing an increase in payment. However, physicians who have been billing 99234 to 99236 and physicians who have been billing 99238 or 99217 for stays less than 24 hours in length (for example, where the patient was in the hospital at the time of the midnight census) would see a small reduction in payment. This policy clarification will give clear guidance to physicians and Medicare contractors in reviewing medical records and would assure consistent payment across contractors.

G. Ocular Photodynamic Therapy and Other Ophthalmological Treatments

As previously stated, we would establish national HCPCS codes and payment amounts for ocular photodynamic therapy. If we did not establish national codes and pricing for this procedure, carriers that determined that this procedure is covered would use unlisted codes and determine pricing locally. There will be no budget effects associated with establishing national codes and payment amounts for this service since national pricing would substitute for use of unlisted codes and carrier pricing.

H. Electrical Bioimpedance

As stated earlier, we are establishing a national payment amount for electrical bioimpedance. This change will have little impact on the Medicare program costs. It establishes national pricing amounts for a service currently priced by carriers.

I. Global Period for Insertion, Removal, and Replacement of Pacemakers and Cardioverter Defibrillators

We are proposing to change the global period for certain CPT codes involving the insertion, removal, and replacement of pacemakers and cardioverter defibrillators from 90 days to 0 days. We would also implement interim RVUs to account for the change in the global period from 90 to 0 days. Since we are making RVU adjustments to accommodate the change in global period, we do not anticipate any costs or savings. There is no redistributive impact of this proposal since it only effects

physicians that insert, remove or replace pacemakers or cardioverter defibrillators.

J. Antigen Supply

Our proposal to change from a 12-week to a 12-month supply of antigen could benefit beneficiaries since they could obtain a year's supply of medication in a single visit. We anticipate that this proposed change would have no impact on program costs. There is no redistributive impact of this proposal since it only aggregates four prescriptions into one and the cost to the beneficiary remains the same.

Other issues mentioned in the preamble are merely discussions or clarifications and, therefore, have no budgetary impact.

Budget-Neutrality

Each year since the fee schedule has been implemented, our actuaries have determined any adjustments needed to meet the budget-neutrality requirement of the statute. A component of the actuarial determination of budget-neutrality involves estimating the impact of changes in the volume-and-intensity of physicians' services provided to Medicare beneficiaries as a result of the proposed changes. Consistent with the provision in the November 1998 final rule, the actuaries would use a model that assumes a 30 percent volume-and-intensity response to price

reductions.

Impact on Beneficiaries

Although changes in physicians' payments when the physician fee schedule was implemented in 1992 were large, we detected no problems with beneficiary access to care. Furthermore, since beginning our transition to a resource-based practice expense system in 1999, we have not found that there are problems with beneficiary access to care.

VIII. Federalism

We have reviewed this proposed rule under the threshold criteria of EO 13132, Federalism, and we have determined that the proposed rule does not significantly affect the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, HCFA proposes to amend 42 CFR chapter IV as follows:

Part 410--SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In §410.68, republish the introductory text and revise the introductory text for paragraph (b) to read as follows:

§**410.68 Antigens: Scope and conditions.**

Medicare Part B pays for--

* * * * *

(b) A supply of antigen sufficient for not more than 12 months that is--

* * * * *

PART 414--PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395(hh), and 1395rr(b)(1).

2. Revise §414.22(b)(5)(i) to read as follows:

§414.22 Relative value units (RVUs).

* * * * *

(b) * * *

(5) * * *

(i) Usually there are two levels of practice expense RVUs that correspond to each code.

(A) *Facility practice expense RVUs.* The lower facility practice expense RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center when the physician performs procedures on the ASC approved procedures list. (The facility practice expense RVUs for a particular code may not be greater than the non-facility RVUs for the code.)

(B) *Non-facility practice expense RVUs.* The higher non-facility practice expense RVUs apply to services performed in the following settings: a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, *or* a facility or institution other than a hospital or skilled nursing facility.

(C) *Outpatient therapy services.* Outpatient therapy services billed under the physician fee schedule are paid using the non-facility practice expense RVU component.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: _____

_____

Nancy-Ann Min DeParle

Administrator, Health Care Financing Administration.

Dated: _____

_____

Donna E. Shalala

Secretary.

BILLING CODE 4120-01-P